			C+	ate of Manyland / Den	autocout of Llouith and A	سنسبيا السفسية		
-			_ State		artment of Health and Martificate of Death	ientai Hygie	ene 2011	43501
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	runcate or Death	Reg 2. Date of Death	. No.	T
	Physicia Medic	al	Barbara Alex	ander		December		3. Time of Death 455 AM
	Examin	er	4a. Facility Name (if not institution, give street and SOUTHORN) WCCSA	A	4b. City, Town, or Location of Death	3	4c. County of Death	eorges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		578 - 96 - 6492 1 □ M 2 Usual Residence of Decedent	2 18 F 47 Yrs.		May 4	1964 Inlas	1.100
	uryland a-f sho ied at	ctor	10a. State 10b. County	10c. City, Town or Lo	ocation	, ,		0d. Inside City Limits 1 Yes 2 □ No
	or 288	Dire	10e. Street and Number	MAshingt	10f. Zip Code	100	. Citizen of What Cour	
	s 23a o	Funeral Director	40 Elmina St.	5.W	20032	Tog	u sa	ru y :
	death r item iner n	Fur	Ar	med Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	s after ral", o	ed by	1 X Never Married 2 ☐ Married 1 If 3 ☐ Widowed 4 ☐ Divorced Ye	☐ Yes 2 🗖 No Yes, Give ear or Dates.	1 ☐ Yes 2 🔣 No Specify:		0	ack
2-0	2 hour	plet	15. Decedent's Educatio (Specify only highest grade con		dent's Usual Occupation kind of work done during most of working	16	b. Kind of Business/In	
121	thin 7	Completed			O NOT use retired)	'S	0. 0	
d 2	Hygid other ent, t	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maid	den Surname)	Are
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	잍	James I.	Alexander	Wilhelm		Adam	5
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type, Prin	Q 11	ng Address (Street and Number or Rura	Λ	1407	
	f Heal item S		20a. Method of Disposition	15 ther 17800	73.0	ate 200	c. Location - City or To	2060 R
Baltimore,	Page nent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State Resume	matory or other place)	2212	Blinton	MO
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility	D.	Janaco M	^
		1	23a. Part 1. Enter the disease, or complication	ns that caused the death. Do not ent	tcl4ins Fuen the mode of dying, such as cardiac of	respiratory arrest,	1guago VI	Approximate
S.	Physician/		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	Mypicardian	L Infarction			Interval Between Onset and Death
	Medical Examiner		resulting in death) a	Due to (or as a consequence of):	11110101101			111/14 65616-16-
		Jer	Sequentially list conditions, if any, leading to immediate b. —	Due to (or as a consequence of):				
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c					
	be executed sician and burial-transi	cal E	resulting in death) Last	Due to (or as a consequence of):				
		edic	d					
9289	eath certificate b attending physi d for use as the b	M/M	23b. Was decedent pregnant	yes, outcome of pregnancy	7		23d. Date of delive	erv
Вох	Hospital or Attending Physician: The law requires that the death certificate 44 hours after death. 44 hours after death. 45 hours after death. 46 hours after death. 47 hours after death. 48 hours after death. 49 hours after death. 49 hours after death. 49 hours after death. 49 hours after death. 40 hours after death. 40 hours after death.	Physician/Medi	1 Ves 2 Vo	☐ Live Birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐ ☐ Unknown	Other (specify)		Month	Day Year
P.O.	es that the dea igned by the a be detached f		Part II. Other significant conditions contributi	ing to death but not resulting in the u	Inderlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Js, F	uires t	ed by	Digodes Mel	litus		1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
Records,	law require has been si je 2 should l	Completed	itype tension	<u> </u>		24a. Was an autopsy	24b. Were autop	sy findings available
Re	hysician: The lav nis certificate has I director, page 2	Con				performed	? death?	
ita	ician: certific rector	Be	25. Was case referred to medical examiner?	l:	26. Place of Death (Check			
_ <	Phys rthis eral di	요	1 L Yes 2 1 No	1 Inpatient 2 ER/Outpatien a. Date of injury 28b. Time of	nt 3 ☐ DOA	ne 5 Residence	e 6 Other (Specify)	
on c	ittending death. stor: Afte y the fun	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year) injury	work? M 1 Yes 2 No	od. Describe flow in	ijury occurred	
Division of Vital	al or Attending P s after death. I Director: After t d in by the funera	Certificate;	3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
۵	To the Hospital or within 24 hours after To the Funeral Directory filled in the		29a, Certifier 1 Certifying Physician; T	o the best of my knowledge, death of	occurred at the time, date and place, and	due to the cause(s	s) and manner as state	d
	the Ho nin 24 ihe Fu ipletel	Medical	(Check 2 L. Medical Examiner: On	the basis of examination and/or invest	tigation, in my opinion, death occurred at t death occurred at the time, date and plac	he time, date and pla	ace, and due to the cau	se(s) and manner stated
	Neith Co.		29b. Signature and title of certifier		29c. License number		Date signed (Month, D	
			Mash Jan	v, MO	D-06/01/31	De	comber :	31,201
alt.	5		30 Name and address of person who complete ALCHIEC DQU'		rint) 3 SURRBTIS RCA.	D CLINTO	EN MD 2	20735
	Stat Registra	C .	31. Date filed (Month, Day, Year)	2. Registrar's Signature	A.J			

DHMH 17 Rev 06-2011

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			For State Registrar #26,					partment of			_	•	201	1 435	502
A	mended	1t	Registrar #26 Decedent's Name (First,		12per phy	ysici	an Oc	i lincale oi	Deaui	D.H.	2. Date of De	Reg. N	0.	3. Time of Do	eath
	Physicia Medi		Raymond L1o	yd Adki	ns, Sr.		_				Month	28	2011	11:15	PM
	Examir		4a. Facility Name (if not ins	titution, give stre	eet and number)	i		4b. City, Town,			•	40	c. County of Dea		
	Funeral		5. Social Security Number	OS PICE		(In yrs. la	st birthday	if Under 1 Yea	f If Unde	er 24 Nos.	8. Date of Bir	th	ا زدد،	rthplace (State or F	oreign
k.	Director		215-26-5773	- X-	M 2 □ F 81_		Yrs.	Months Days			087277	1930) Ber	Tin MD	oreign
	how at	۱	Usual Residence of Deced 10a. State 10b. 0	entCounty		10c, City	, Town or L	ocation				_		10d. Inside City	Limite
	// Aarylar 8a-f s tified	recto	MD Wo	rcester			n City							1 X Yes 2	
	th the Maryland 3a or 28a-f show be notified at		10e. Street and Number	recour		occui	1 010	10f. Zip Code				10g. C	itizen of What C	ountry?	
1	th with ms 23a must b	Funeral Director	13803 Saili		W Deceler		Lie	218				USA			
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Iedical Examiner must be notified at	ρ	11. Marital Status 1 Never Married 2 3 Widowed 4 Di	X Married	. Was Decedent E Armed Forces? 1 Yes 21		. 113.	. Was Decedent of If Yes, specity Cu	oan, Mexic	an, Puerto F	offy Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: whi	te, etc.	
21215-0036	hours a	Completed	15. C	Decedent's Educa			16a. Dec	edent's Usual Occi				16b I	Kind of Business		
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721	d wi dygie ther nt, t	0	12 17. Father's Name (First, M	liddle Leet)			Post	al Worker	1				S. Post	Office	
and	be file ental h ked o ic eve	70 E	Lawrence Ad							ther's Name e Sma.c	(First, Middle, : k	Maiden	Surname)		
Maryland	of Health and Mental F fitem 27 is marked of r other traumatic ever		19a. Informant's Name/Re		Print)		19b. Mai	ling Address (Stree	t and Num	ber or Rural	Route Numbe	er, City o	r Town, State, Z	ip Code)	
∑	and 2 s Health s em 27 i ther tra		Diana Clark		hter)		2 A	bbey Lane	e, Ber	rlin,	MD 218	11			
Baltimore,	ge 1 a tr of H :: If ite		20a. Method of Disposition 1 🔀 Burial 2 🗌 Crer	mation 3 🗆 Re	moval from State	Ce	emetery, cre	position (Name of ematory or other pi			ate		ocation - City o	Town, State	
i ii.	permit. Page 1 a Department of F Important: If its any injury or ot		4 Donation 5 0	Other (Specify) ervice Licensee		Eve	-	n Cemete	- :	1/2/2			lin, MD		
Ba	lmp any		1 1/ The	1	fale			108 Will:		T 11C	Burba Lin, M	ige . ID 2	Funeral 1811	Home	
			23a. Part 1. Enter the dise shock, or heart failure	ease, or complicate. List only one of	ations that caused	the death	. Do not en	iter the mode of dy	ing, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Betwe	en
1	Physician/		Immediate Cause (Final disease or condition	a.	U		57	FROKE						Onset and Dea	
-	Medical Examiner		resulting in death)		Due to (or as a	conseque	ence of):								
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89 >	death certificate I ne attending phys ed for use as the	an/N	IF FEMALE: 23b. Was decedent pregna	2111	. If yes, outcome o			☐ Ectopic pregna	ncv				23d. Date of de	elivery	
Box (requires that the death certificate to been signed by the attending phys should be detached for use as the	by Physician/Medi	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5?	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)					Month	Day Yea	ır
P.O.	Attending Physician: The law requires that the refeath are death. strack After this certificate has been signed by the funeral director, page 2 should be detached.	y Ph	Part II. Other significant c	conditions contri	buting to death bu	ut not resu	Iting in the	underlying cause	given in Par	rt I.	23e. Did t	obacco	use contribute to	the cause of deat	th2
ds,	quires en sign	ted k									1 🗆	Yes 2	□ No 3 □ F	robably 4 Un	known
cor	≥ 85 ≤	Completed									24a. Was auto	psv	prior to	topsy findings ava	ilable se of
Re	: The I cate h	Con									1 Yes	ormed?	death?	s P No	
/ita	sician certifi irector	b Be	25. Was case referred to per examiner? 1 ☐ Yes 2 ☐ No	edical Hos	pital:		- D/O:	10	hor	eath (Check			N	Coasta	1
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on	eath. or: Aff	fical	2 Accident	Pending Investigation Could not be	(Worth, Day,	rear)	irijury		rkí? ☐Yes 2[□No					
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:		determined	28e. Place of Inju- building, etc.		ne, farm, st	treet, factory, office		2	8f. Location (City or Tov			ral Route Number,	
_	Hospita 24 hours Funera sted fille	Medical	(Check 2 ☐ Me	edical Examiner:	On the basis of ex	amination	and/or inve		nion, death	occurred at t	he time, date a	and place	e, and due to the	cause(s) and manne	er stated.
	To the within To the Somple		only one) 3 ∐ Cer 29b. Signature and title of o		ractioner: To the t	est of my	knowledge,	death occurred at 29c. Licen	the time, da se number		, and due to th		s) and manner as ate signed (Mont		
			VUM	lun	w		MD	D	6051	15		12	130111		
0			30. Name and address of p	person who comp	oleted cause of de	ath (Item	23a) (Type,		001		Chi.	c 12		DOLA	5/1
D	N 15		31. Date filed (Month, Day,	MANUT	32. Resistra	7/C) t/	TSIERN	51-101	LE DR	1 2961,	55V	RY /VI.	DZ180	4
	Sta Registr	i.e	1 R 1		9	and a	1. 1	parker							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death December 27, 2011 Daisy Denise Anderson 9:56A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8440 Kentucky Ave. La Plata Charles 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours ugust 8, 1959 220-74-7425 1 □ M 2 🔽 F Maryland 52 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD La Plata Charles 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8440 Kentucky Ave. 20646 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black White etc. 2 **X**No Yes 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify White Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Franklin Racey, Sr. June Marie Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Anderson/Husband 8440 Kentucky Ave. La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
St. Ignatius Hill Top 12/31/2011 1 Burial 2 Cremation 3 Removal from State Hill Top, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 8 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to lor as a conservience of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Rhysician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other transmitted.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and physician a attending p for use as t signed by the a d be detached f has e 2 page, certificate this

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 n 24 hours after death.

E Funeral Director: After teleted filled in by the funeral

ਵ ≒ ਵੇ ≎	2	only only of a contributed for the best of the knowledge, dealt
Not		29b. Signature and title of certifier
60-15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K-MATHUE, PO BOX
Stat	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signature

2012

0 Registrar's Signature

Physician/Medical þ Completed 25. Was case referred to medical Be examiner? 1 Yes Hospital: 2 1 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 AResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Vatural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29d, Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 43504 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond Amirault Joseph 2011 11:45 December A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) June 08, 1949 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Days 1 🗶 M 2 🗆 F 62 027-36-6909 Massachusetts Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2 X No 10e, Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21227 USA 5605 Ashbourne Road within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō þ 1 Never Married 2 Married Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Machine Operator Box Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Gerald Amirault Marie McConnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 328 Cresswell Road Brooklyn Park, MD 21225 Albert S. Amirault / Brother Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Important: Metro Crematory, INC injury (Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Inter the grease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death TROINTESTINAL Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BDOMYOL Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Tyes Hospital or Attending Physician: **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. **To the Funeral Director**: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of preserved at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis preserved at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed only one) Certifying Nurse Practioner: the best of my sowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 00061765 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILLEWS AVE #307 BAL State 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#1, PER MD 6933 11/1/12 TRT
State of Maryland / Department of Health and Mental Hygiene 2 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ENMA MARIA ALVARADO AMAYA 2. Date of Death 3. Time of Death Month j Physician/ 0949 м 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0+ Baltimore Maryland Medical University 7. Age (In yrs. last birthday) 24 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 8. Date of Birth 3 1/0/2, Pal, 9-8/7 9. Birthplace (State or Foreign 1 □ M 2 🛎 F Months Min. none EPourSalvador **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MDAnne Arundel Glen Bernie 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1902 Oakley Road 21061 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☑ Yes 2 □ No Specify:
Sal Vadoran 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No ō Black, White, etc 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 Specify: White 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baby sitter Child care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cesar Romeo Alvarado Herrera Maria Paula Amaya 19a. Informant's Name/Relationship (Type, Print)
Yenis Alicia Flores/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Oakley Road Glen Bernie, Md 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Date Anuachapan, Cemetery crematory or other place, General 1 ☑ Burial 2 ☐ Cremation 3 ☑ ☑ moval from State 1/07/2012 4 ☐ Donation 5 ☐ Other (Specify) El Salvador BHTTTP dos KINALDI EUNERAL SERVICE, P. A. 9247 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hely failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rectal cance disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** nacterem Sequentially list conditions, Examine if any Latting to immediate cause. Enter Underlying attending physician and for use as the burial-transit the Hospital or Attending Physician. The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknow Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been si funeral director, page 2 should h 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider 5 Pending death. Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier December 25th, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boutimore MD 2/20 22 S. Behany A. Weiter MD Greene St. 31. Date filed (Month, Day, Year) State JAN 0 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per med cert G924 2/6/12 dk
State of Maryland Poepartment of Health and Mental Hygiene 43506 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Z 5 th Month December Physician/ Loc Ta Avery 8:45 FM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Center Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) May 22, 1927 Hours 579-80-3293 **Director** 1 □ M 2 🗓 F 84 Vietnam Usual Residence of Decedent show ims 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges MD Temple Hills 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 4121 28th Ave. 20748 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, l Hygiene. Lother than "natural", or iter vent, the Medical Examine⊡ 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Voice of America Broadcaster Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname) Liem Pham 17. Father's Name (First, Middle, Last) ည Dung Ta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4121 28th Ave., Temple Hills, MD 20748 Joseph H. Avery, Sr./Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fairfax Memorial Park 1 X Burial 2 ☐ Cremation 3X Removal from State Dec 2011 Fairfax, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 21. Signature of Funeral Service Licensee Kambed Best CC0423 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician | Anoxic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): in and Examir nour Status Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Vear signed by the at d be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Asthma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Completed peen Myounded Inforction Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? performed? Impaired 2 No Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) within 24 hours after death.
To the Funeral Director. After this cell completely filled in by the financial. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2714 December 2011 D-52865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Rd ste 200 Glenn Ode MD FILARD 31. Date filed (Month, Day, Year) **JAN 05 2012** 2. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43507 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31,2011 Physician/ Linda Denise Black December 6:45 P.M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 52 Months Davs Hours Min. 08/18/1959 Director Wash.,D.C 578-84-2362 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No Md. Fairmount Heights P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 708 59th Place 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", 3 - Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) the Packer Moving Company Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eventance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Spriggs, Sr. Mary Louise Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Black/Son 6210 Kolb St., Fairmount Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 01/06/12 Landover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -Physician/ disease or condition resulting in death) Metastatic Freast Cancer 3 mos. or mare Medical Due to (or as a consequence of) Examiner Renal Failure with Hyperkalemia mos. or more Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exami as the burial-transit or Attending Physician: The law requires that the death certificate be executed <u>Septic Shock</u> davs and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician tached for use as the buria Physician/Medical Small Bowell Ileus 24 hours + Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? Yes 2 No this certificate 2 🗌 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/31/11 MD0068038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

(Month, Day,

JAN 1 0 2012

Uzoamaka Nwaogwugwu, M.D. HMG of Prince George's Hospital, Cheverly, Md. 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43508 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1:10P M 2011 Audrey Decembei Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u> Clinton Nursing & Rehab.</u> Center Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day,) Months Country) Wash 1 ☐ M 2 🛣 F Days Hours Director 1930 <u>579-38-0054</u> May , DC Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Clinton 10e Street and Number ō 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 9211 Stuart Lane 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Univ. of Maryland Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental | is marked o မ Joseph Bertha DeVaughn Mercer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1910 Crain Highway Monique Taylor/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery! 1/6/12 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 231. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Interval Between Onset and Death ediate Cause (Final Physician/ disease or condition resulting in death) Arteriosclerotic Heart Disease Medical Due to (or as a consequence of) Examiner Cerebral Vascular Disease Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Duy to (or as a nonsistum to of Examir attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day signed by the a d be detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 s performe 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 - No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier auce in D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tanner, M.D., 11701 Livingston Rd., Ft. Washington, MD 20744 31. Date filed (Month, Pay, Year)

JAN () 9 2012 State Registrar

P.O.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registra AMFND#220erFH, 1/6/12; BMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ CRISTINA AIMEE PALMA BAIGORRI 13:100 Medical ecember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery HOLY CROSS HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) NONE Director 1 □ M 2 🏋 F December 20,11 United State 0 2 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X 1 Yes 2 No MD PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 Funeral 6200 20th Ave items 23a United State 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1Ⅺ Yes 2□No Specify:Argentine "natural", 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Natalia Adriana Baigorri Julio Edgar Palma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julio Edgar Palma (Father) Important: If item 27 any injury or other tra Page 1 and 2 20th Ave Hyattsville, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Crematy of Expatory or other place)
Riverdale Park 20c. Location - City or Town, State Date Department of 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/13/11 Riverdale, Maryland 22. Name and Address of Facility Cruz Funeral Services, 21. Signature of Funeral Service Licensee 600 Kennedy ST, Nw. Washington, DC 20011 23a. Part T. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hours Immediate Cause (Final Physician/ disease or condition resulting in death) Pulmonary Hemorrhage Medical Due to (or as a consequence of) Examiner days Extreme Prematurity Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician --Cause (Disease or injury days Extreme Low Birth Weight that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be days Respiratory Distress Syndrome Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 performed? Yes 2 N 1 Yes 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes ပ Inpatient 2 - ER/Outpatient 3 - DOA 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28h Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be within 24 hours after deal To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/22/11 D57151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1500 Forest Glen RD. Silver Spring, MD 20910 DAWN WALTON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

31. Date filed (Month, Day, Year)

JAN 06 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Helmut Bottier **4** M 5:50 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltmure University If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 - F Month, Day, Year New York 113-34-2056 **Director** 944 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 10d. Inside City Limits 1 Yes 2 X No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5860 Cari Road 20639 ı "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 White If Yes, Give 1 Yes 2 X No Specify: Specify: 3 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Prince George's (Give kind of work done during most of working life. DO NOT use retired) than Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Mo College (1-4 or 5+) Elementary/Seconday (0-12) Police Officer County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emma Diers John Bottjer 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Nancy Bottier 5860 Cari Road Huntingtown, MD other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o # i Janüärv 4 1 🔣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Miranda Cemetery Huntingtown, MD 2012 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Gary J. Goff 20736 8125 Southern Maryland Blvd. Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Pnysician/ Metastatic Gastne disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of) Exami death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year ☐ Yes ∠ ☐ ☐ Unknown Unknown ul or Attending Physician: The law requires that the after death.

Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease Arter 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tyes 2 😿 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours af

To the Funeral Di

completed filled in Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8091083127 Vineet Sandhu 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Macy land 12 South Greene

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28, 2011 3:55 A.M Norvelle H. Beatty December Medical 4c. County of Death Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Homewood at Crumland Farm If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Dec. 12, Year) 913 98 Texas 384-18-9961 **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 7407 Willow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2X No Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United Negro College I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5 Fund Raiser Fund Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Ludella Caldwell Benjamin Harrison other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Neal Court, Silver Spring, Maryland 20901 Department of Health an Important: If item 27 is 1 any injury or other traum once. Robert D. Brown, Jr - friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 1-5-2012 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Astensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) VEALG Medical Due to (or as a c equence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Day Year Pregnant at time of death 1 L Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy 1 Yes 2 No Yes 2 No **Division of Vital** funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred I or Attending Fafter death. injury Natura! 5 Pending 2 Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

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physicians as, norvelle

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item

Casper E. Cline, M.D.

32. Registrar's Signature

29c. License number

MDD16428

^{em 23a)(Type, Print)} 300 W. Ninth Street, Frederick, Mary⊻and

29d Date signed (Month.

21701

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

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		19a. Informant's Name/Relationship (Type.	. Print)	19b. Mailing Address (Stree	t and Number or Rura	I Route Number, City	or Town, State, Z	'ip Code)				
		Carol C. Rafferty N	liece	946 Middle Gr	round Ave 1	Rolesville	NC 2757	1				
- 1		20a. Method of Disposition	608	ce of Disposition (Name of netery, crematory or other pl	ace) D	ate 20c.	Location - City or	Town, State				
		1 ♠ Burial 2 □ Cremation 3 □ Rerr 4 □ Donation 5 □ Other (Specify)	noval from State Park	wood Cemetery	01/03	/2012 Ba1	timore,M	D				
ouce.		21. Signature of Funeral Service Licensee		22. Name and Addi	ess of Facility	851	Annanol	ie Road				
ō		Vally U	1/ L		Funeral Hor		brills,M	D°21054	· ·			
		23a. Part1. Enter the sease, or complicat shock, or heart failure. List only one	tions that caused the death. cause an each line.	Do not enter the mode of dy	ring, such as cardiac o	r respiratory arrest,		Approximate Interval Bety Onset and D	reen .			
in .		Immediate Cause (Final disease or condition resulting in death)	Ineuma	onda				Offiset and D	eau			
al er		resulting in death)	Due to (or as a consequer	nce of):		6			-			
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	Examiner	Cause (Disease or injury that initiated events	Denre	ntia								
	ŭ	resulting in death) Last	Due to (or as a consequer	nce of):								
	ical	d										
	led											
Ì	2	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregnanc				23d. Date of deli	very				
	icia	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										
	hys	9 ☐ Unknown 9 ☐ Unknown										
	N N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Ì	Completed by Physician/Medical	Injected Stage TV Prissure Ulcor 1 1 Yes 20 No 3 Pro										
	ete	Atral Fibril	IP F			24a. Was an	24h Mora au	topou findingo a	veileble			
	ш	HIVEAU PIDIT	rac ((OV)			autopsy performed?	prior to o	topsy findings a completion of ca	use of			
						1□ Yes 2 🗷 N	lo 1 ☐ Yes	2 No				
	Be	25. Was case referred to medical examiner?	spital:		26. Place of Death	(Check only one)						
	၉ .	1 les 2 140	1 ☐ Inpatient 2 ☐ EH	Voutpatient 3 DOA		ne 5 Residence		cify)				
	.: 0	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury Wo		28d. Describe how inj	ury occurred					
- 1	cati	2 Accident investigation]Yes 2□No							
	Medical Certification:	4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, factory, office	2	28f. Location (Street a City or Town, Sta		ral Route Numl	oer,			
	2	29a. Certifier 1 ✓ CertifyIng Physici	ian: To the best of my knowle	edge, death occurred at the	time, date and place, a	and due to the cause	s) and manner as	stated.				
	G	(Check only 2 Medical Examiner one)	r: On the basis of examination and manner stated.	n and/or investigation, in my	opinion, death occurre	ed at the time, date a	nd place, and due	to the cause(s)				
	×	29b. Signature and title of certifier		29c. Licen	se number	29d. D	ate signed (Month	n, Day, Year)				
		Dian.	MT		51596	Tou	4440 7	nel Del	٠, ٦			
	-	30. Name and address of person who comp	pleted cause of death (Item 2)	3a) (Type Print)	, , , ,	Val	ruary a	201	d-			
W		K-Ambalavanar	7845 Oa	Ewood Ro	ad ale	n Burnie	- MD	2106	i .			
Stat		31. Date filed (Month, Day Year) 5 20	10 32. Registral's Signatur	· 1 1								
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1/20	01			~								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC 201111:02 AM DIANE NORMA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA WRNMMC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎛 F Days May 08, Months Min. 1939 Wisconsin 72 **Director** 397-36-4534 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No VA Fairfax Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7404 Tomcris Court 22153-1353 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Yes 2 No Yes, Give 11-Baltimore, Maryland 21215-0036 If Yes, Give 11-06 Year or Dates 07-3 1 ☐ Yes 2 kg No Specify. Specify: White "natural", Completed 3 Wildowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Asst. Chief Nurse U.S. Army Nurse Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norma Alfrieda Rager Elmer Marvin Ankerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> and 2 s Health s Kenneth P. Butke -7404 Tomcris Court, Springfield, VA 22153-1353 Husband item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or of ☐ Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) National Crematory 1-8-2012 Falls Church, Virginia Signature of Funce Service Licenses 22. Name and Address of Facility Demaine Funeral Home 5308 Backlick RD, Springfield, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC NON-SMALL CELL LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and James Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death the hed 9 Unknown P.O. ed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending work Division 1 🗌 Yes within 24 hours after death

To the Funeral Director. /

Completed filled in by the f Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 12.29.2011 0101246396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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JAN 1 0 2012

BROWN,

MD

GREGORY

31. Date filed (Month, Day, Year)

CPT USA

WRNMMC, BETHESDA, MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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			Registrar 1. Decedent's Name (First, Middle,	Last)			ertificate	OIDE	eatri ————	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia Medic		Lubie May Cr							Month 12	Day	Year 2011	3:30 PM
	Examin		4a. Facility Name (if not institution,		tal				ocation of Death		4c. Count	y of Deat	th -
	Funeral		5. Social Security Number		e (In yrs. la		ay) If Under	1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birl		9. Bir	thplace (State or Foreign
	Director		238 22 5518 Usual Residence of Decedent	T	88	Yr	S			2/23/	1923		NC NC
	Iryland I-f shor	Director	10a. State 10b. County				r Location						10d. Inside City Limits 1 X Yes 2 □ No
	the Ma or 28k		MD 10e. Street and Number			Jarc	10f. Zip				10g. Citizen of		
	th with ns 23a must b	Funeral	4413 St. Geo:					2121			US		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Inpropriant: If item 27 is marked other than "natural", or items 23a or 28a-f show mary injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Married 2 ☐ Marries3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	_	5. 	13. Was Deced If Yes, spec		panic Origin? (Spe Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Bla	ace - Ame ack, White y : \mathbf{Bl}	
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212	within giene. er thar the M		Elementary/Seconday (0-12) 4th	College (1-4 or 5	i+)		e. DO NOT use m Labe				Priv	ate	
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Maryland	nould b nd Mei s mark umatic		19a. Informant's Name/Relationshi			19b. N	failing Address		d Number or Rura			State, Zi	p Code)
ž	nd 2 sh ealth a m 27 is ner trai		Eva Mae Maye/	Daughter		1	-		ge Ave.				
Baltimore,	age 1 a ant of H tr. If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		C	emetery,	isposition (Nam crematory or or	ther place)	1	Date 1 / 1 1	20c. Location	•	
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	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):	1.7						
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09		dical		d									
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	I death	3 Ectopic p 5 Other (sp					Date of de Month	blivery Day Year
<u>0</u>	requires that the der been signed by the s should be detached	y Ph	Part II. Other significant condition	_						23e. Did t	obacco use cor	ntribute to	o the cause of death?
rds,	een sig tould b	eted !	Corney orte	y disease	ny	peri	milion	Di	chites	1 🗆			Probably 4 Unknown
Reco	Physician: The law r this certificate has b al director, page 2 sh	Comple	mellers, A	trial fibrill	ahon	•				24a. Was autoj perfo 1 🗆 Yes	osy ormed?/	prior to death?	utopsy findings available completion of cause of
/ita	rsician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	FB/Outn	atient 3 🗆 DC	Other	e of Death (Check		dence 6 🗆 Ot	her (Sne	cify)
of \	ing Phy I. After this uneral o	ate: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of inju	ry	28b. Tin inju	ne of 2	8c. Injury a work?	at	28d. Describe h			5117)
ivision	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 280 Place of Init	ury - At ho	me, farm	, street, factory		es 2 🗆 No	28f. Location (S City or Tov		ber or Ru	ural Route Number,
	ne Hospita n 24 hours ne Funeral pleted filled	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of c Nurse Practioner: To the	xamination	and/or i	nvestigation, in r	my opinion,	, death occurred at	t the time, date a	and place, and c	lue to the	cause(s) and manner stated.
	To the		29b. Signature and title of certifier	20.5			1	. License r			29d. Date sign		
	ma-3		30. Name and address of person w	tho completed cause of d	eath (Item	23a) (Ty	pe, Print)	ESO	Lech 0 -	We. 01	12/24,	")	ms, 21239.
) is	Stat	e	Ananta Subldina 31. Date filed (Month, Day, Year)	ni); Govd Sa 32. Registr	ar's Signat	ure ,	103 1001	1-001	2011	· (n 151V	or , want	nort	M), 41439,
	Registra	ar	JAN 0 3 20	12 Sener	A.	100	who						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 25. Physician/ 2011 Day 7:19 A William Preston Carr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Director 577 26 4046 Usual Residence of Decede 1 □**X**M 2 □ F 85 Yrs. Virginia Feb 2, 1926 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 3916 Ames Street N.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?

▼Yes 2 □ No WW 1 Never Married 2 Married 1 Yes (ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: **Black** 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) United States Postal Service Mail Handler 9th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Rachel A. Taylor injury or other traumatic William Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important If item 27 is any injury or with 3916 Ames Street, N.E. Washington, DC 20019 Bernice A. Carr (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1/5/2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ expulpalmonum Seconds disease or condition resulting in death) Medical Examiner minules Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last e attending physician and for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the death Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\sigma\) after death.

Director: After this certificate within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 NO 1 Inpatient 2 NER/Outpatient 3 DOA Certificate: 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dool 8207 December 25 72011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont Registrar's Signat

Registrar

Please Type or Print in Black Indelible Ink Forume All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 30 2011 Scott Ludwig Carmichael Dec. 7:05A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 215 96 7621 48 **Director** 1 🔼 M 2 🗆 F 9/12/1963 DC 28a-f show 10a. State 10b County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 XYes 2 No MD Prince George' Upper Marlboro ō 10e Street and Number 10g. Citizen of What Country? Funeral items 23a 10307 Duke of Wellington Ct. 20772 Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, P. þ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: natural" Completed 3 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other tha 0 Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vaughn Carmichael Patricia Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Vaughn Carmichael/Father 7976 High Rock Rd.West Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 1/3/2012 | Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam and the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): at ending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for Day Year 5 Other (specify) the 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Director: After this certificate I 2 No Yes 2 X No 1 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 No Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Funeral [Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Contifying Number Prantition of Temperature at the control of the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the control of the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) and manner stated 3 Contifying Number Prantition of Temperature at the cause (s) within 2 To the I occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 069737 11/65 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/2/5 7503 SURPATTS ROAD CLINTON MD 20735 SUDHEER ROMMU gistrar's Signature 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Day Physician/ Month 12 Louann Patricia Collins $2\overset{\scriptscriptstyle{\mathrm{Ye}}}{0}\overset{\scriptscriptstyle{\mathrm{T}}}{1}$ 18:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Birting Country MD Days Hours Min 1 ☐ M 2 🔀 F Months 11/10/1942 Yrs 69 Director 219-38-1743 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49 Falling Leaf Court 21157 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward McCourt Louise Minck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Lee Collins/husband 49 Falling Leaf Court, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crestlawn Cemetery 01/03/2012 Marriottsville, MD . Signature of Funeral Service Licensee 22. Name and Address of Farritts Funeral Home and Chapel, PA Tail B 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between **Qnset and Death** Immediate Cause (Final Physician MUICHTIZON DIFFICILLY ENTERITIS disease or condition resulting in death) Monk Medical Due to (or as a consequence of) Examiner Esquisitiony list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Yea Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the a 1 ☐ Yes 2 ☐ Unknown t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes cate has been spage 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate Yes 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide after determined n 24 hours after le Funeral Dire pleted filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune

completed 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (Sale + Ty 2/2012 ما المرك 031666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James K. Chambers 12:15 P M December 2011 Medical 4a. Facility Name (if not institution, give street and number) Bethesda **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Health and Rehabilitation Center Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Social Security Numbe Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Davs Hours (Month, Day, Year) **Director** 147-01-8606 1 🕱 M 2 🗆 F 98 Yrs. 12/19/1913 New Jersey Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State the Maryland 10c. City. Town or Location 10d, Inside City Limits Director MD Montgomery Bethesda 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20814 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1941

| X Yes 2 | No 941
| If Yes, Give 1045 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the Theatrical Lighting Theater Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Husky William Chambers ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Chambers Jr. 408 Kennedy St. NW #301 Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page
Department of
Important: If
any injury or
once. Falls Church, VA National Crematory 1/5/12 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licer 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complication, that caused that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions, it any hearing to immediate cause. Enter Underlying Due to jor as a conse, lience of Examin Hypertension law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Chronic Renal Failure attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Anemia, Myelodysplastic Syndrome 24b. Were autopsy findings available 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 No prior to completion of cause of death? Hospital or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4

✓ Nursing Home 5

— Residence 6

— Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fu death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D53691 29d Date signed (Month, Day, Year) 01/04/201230. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy MD 3200 Tower Oaks Blvd. Suite 110 Bethesda, MD 20817 31. Date filed (Mo JAN 05 2012 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43520 Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 20ÏÎ 4:15 A M Ronald Dawson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles LaPlata Civista Medical Center Date of bill. (Month, Day, Yea If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** 1 **XX**M 2 □ F Min Months Days Hours 68 Illinois 340-36-2520 **Director** October 1943 Usual Residence of Decedent show. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 XXNo White Plains Maryland Charles 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A 20695 10068 Warmsley Ct. Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Tant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status was beceden even in 0.5.
Armed Forces?
1 XX Yes 2 □ No
If Yes, Give Vietnam
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 XX Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Proper 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 Property College (1-4 or 5+) Communications Manager/ Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elmira Wimberly Charles Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10068 Wamsley Ct. White Plains, MD 20695 Evelyn Dawson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Arlington National Cemetery Jan. 25, 2012 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician/ Medical Due to (or as a consequence of) Examiner Years Diabetes Sequentially list conditions, if any, leading to immediate bause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Years burial-transi Hypocholesterolemia that initiated events resulting in death) Last and Due to (or as a consequence of). attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Chronic renal failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No page 2 24 hours after death. Funeral Director: After this certificate has 1 Yes 2 No funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA ပ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending Investigation Accident completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one

To the I within 2 5

State Registrar 29b. Signature and title

address of pe

npleted cause of death (tem 23a) (Type, Print)

Registrar's Signatur

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29c. License number

D0026010

29d. Date signed (Month, Day, Year) December 28, 2011

20685

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4352 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22, 2011 8:48 Рм Patricia Louise Coleman Draher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Director 527-50-6351 1 🗆 M 2 🗶 F 72 Yrs CA. June 23, 1939 show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Charles Waldorf 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20601 United States 2801 Brewster Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces
1 X Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or DatesUS Navy 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HomeMaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Palmer Ludwig B. Coleman Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6053 Red Wolf Place Waldorf, MD. 20603 Kevin Draher / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State MD. Veterans Cemetery Jan. 3, 2012 Cheltenham, MD. Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Examiner Severe Cardiomyopathy Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗆 No Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my homeoge death are medical the time date and place and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of pertifier 00063343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIEN RD. SILVER SPRING MD 741

DHMH 17 Rev 06-2011

State Registrar 1500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43522 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathrm{D}^{\mathsf{Month}}_{\mathsf{ec}}$. ^D2011 Howard Martin Davies 31, 4:55 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 4 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 **X**M 2 □ F Months Hours **Director** 85 New York 134-14-9454 Ĭ926 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Huntingtown 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1261 Matthew Drive 20639 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 \sum No 1944
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: Completed White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operations Manager U.S. Treasury Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Davis Anna Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Richardson - Daughter 1261 Matthew Dr, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of Jan 3, 2012 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State cemetery, crematory or other place) Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 21. Signature of Fune 12 rvice Li 2 ns e 22. Name and Address of Facility Lee Funeral Home Calvert, PA. Ergler 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Strone Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypp. +Pasion Sequentially list conditions, if any, leading to immediate Examine death certificate be executed Cause (Disease or linjury Hypp- apidomo sician and burial-tran that initiated events resulting in death) Last Due to (or as a donsequence of physician s the burial Physician/Medical Box 68760 ending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ò in the past 12 months? Day Yes 2 No Unknown P.O. Hospital or Attending Physician: The law requires that the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2x No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursu Production To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N. Hendono MD 1/3/2012 200606 38 MM NAYANTARA MENDONCA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 FREDERICK 20678 ROAD 310 PRINCE 110. HOSPITAL # 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN - 4 2019 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} 6:05 Medical Svlvia Diamondstein December 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1801 E. Jefferson St. Rockville Montgomery Age (In vrs. last birthday If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 1 🗆 M 2 🗶 F Months Davs Hours Director 95 07/23/1916 136-14-6505 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1X Yes 2 ☐ No MD Montgomery 5 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral Ε. Jefferson St. 20852 be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evance. 2 Louis Sobel Rose Umansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Weiss / Daughter Lily Pond Ct. Rockville, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Hebron Cemetery 01/01/2012 21. Signature of Funeral Service Licenses 22 Name and Address of Facility,
Danzansky-Goldberg Memorial Chapels Inc.
1170 Rockville Pike Rockville, MD 20852 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Inanition Weeks Medical resulting in death) Due to (or as a consequence of) **Examiner** Failure To Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 6 Months Due to (or as a consequence of) Examir The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death
Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 2 🕅 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No after death 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Philip

30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

Henjum,

JAN 1 0 2012

D0035045

18109 Prince Philip Dr. #200 Olney, MD 20832

December 30.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 43524 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Madie Sue Dilworth Physician/ Mpnth 24Day2011Year 6:05 P Medical Eacility Name (if not institution, give street and number)
Larkin Chase Nursing Home **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Bowie If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 94 Social Security Number 425-64-2823 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 F Days Months 6 2 1 2 1 9 1 7 **Director** Yrs Okolona MS be filed within /z now.

Aental Hygiene.

arked other than "natural", or items 23a or 28a-f snow.

Afic event, the Medical Examiner must be notified at Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location
Mitchellville 10d. Inside City Limits Director Prince Georges 1 X Yes 2 ☐ No 10g. Citizen of What Country? USA 10e. Street and Number Funeral 1500 Brady Ct. 20721 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other: any injury or other traumatic event, the Teacher State of Be ¹⁷ Father's Name (First, Middle, Las James Jenkins 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1500 Brady Ct. Mitchellville, MD 20721 Marian R. Dickson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/3/2012 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee NE Washington 22. Name and Address of Facility
Dunn&Sons-5635 Eads 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dvanced disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter charging Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a, Was an Were autopsy findings available page 2 autopsy performe prior to completion of cause of death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be completed filled in by the funeral director 26. Place of Death (Check only one) examiner? Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 24 hours after death Funeral Director: A 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 00514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12200 STE 232 GLEW DALE MD 20769 18 LTOYE UKEOWO ANNAPOLI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/27/2011 Frances L. Eyster 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Chevy Chase 4c. County of Death Montgomery Brighton Gardens Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 077-26-0260 **Director** 1 □ M 2 1 F 87 Philippines Usual Residence of Decedent 01/29/1924 23a or 28a-f shov 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Chevy Chase Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5555 Friendship Blvd. 20815 'natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 XNo 1 ☐ Yes 2 XNo Specify: Specify: White 3X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cellege (1-4 or 5+) Social Worker <u>Catholic University</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vicente G. Lava Ruth Propper 19a. Informant's Name/Relationship (Type, Print) Patty Eyster / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Laverock Lane Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/31/2011 | Falls Church, VA National Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 100 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner End-Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ransit Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) signed by the atter Ectopic pregnancy in the past 12 months?
1 Yes 2X No Pregnant at time of death Month Day Year Unknown 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available in 24 hours after death.

he Funeral Director: After this certificate has pletely filled in by the funeral director, page 2 autopsy
performed?

Yes 2X No prior to completion of cause of death?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted examiner? Hospital: 2X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 $\!\!\!\!$ Other (Specify) $\!\!\!\!\!$ Living 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/28/2011 D55258 of person who completed cause of death (Item 23a) (Type, Print) Wilks MD 7758 Wisconsin Avenue #211 Bethesda, MD 20814 Gary B. 31. Date filed (Month, Day, Year) State 32 Registrar's Signature JAN 05 Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1-ratta reter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11904 Crown Drive Dunkirk If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/11/1933 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-44-2092 78 Yrs Director Usual Residence of Decedent the Maryland 10h County 10c. City. Town or Location 10a. State or 28a-f show other traumatic event, the Medical Examinar must be notified at **Funeral Director** MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2: any injury or other traumatic event, the Mental Processing or Operation of the processing of t 11904 Crown Drive 20754 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman 17. Father's Name (First, Middle, Last) Lucia Zancan ၉ Fratta Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11904 Crown Drive Dunkirk, MD 20754 Mary Fratta Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Our Lady of Sorrows 01/04/2012 22. Name and Address of Facility 21. Signature of Funeral Service Licensee all 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cancel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sease. Enter the origing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

PEPCO 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State West River, MD Hardesty Funeral Home P.A.Annapolis, MD 21401 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Melical Parkway Sute 210

Year

Italy

Race - American Indian, Black, White, etc.

Specify: White

2011

Calvert

USA

-A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ▼ No

الخطا W

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person

and manner stated

o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Franklin, May 12/21/11 (0 133)

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•	th with ns 23 must	Funeral Director	14051 Gallop Te	rrace			20874			Unit	ed Sta	tes
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Maryland	shoul and t		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	g Address (Street	and Numbe	r or Rural Route Number	r, City or To	own, State, Zip	Code)
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Baltimore,	. 0	10.	1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from S	State C	-	atory or other place		Date		ation - City or	
alti	permit. Page Department Important: I any injury or	1	21. Signature of Funeral Service Lice						/04/2012 Simple Tri			Maryland
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e la	Physician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac	used the death h line. r as a consequ	ite	the mode of dyin	g, such as o	cardiac or respiratory arr	est,		Approximate Interval Between Onset and Death
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rds,	equire een si	eted							1 🗆 Y	/es 2 🗌	No 3□Pr	obably 4 Unknown
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Vital	rsicial s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	notiont 0 🗆	ER/Outpatient		r.	(Check only one)			
of	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of (Month, on	injury Day, Year)	28b. Time of injury	28c. Injury	4 □ Nur	28d. Describe ho			fy)
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	Stat		Ahned Heshma 1. Date filed (Month, Day, Year)	completed cause	or death (Item	23a) (Type, Pri	ia Ave	+20	3 Siver	Spr	Twg. Mi	D 20902
	Registra		JAN 1 0 201	2 Sente	~ B.	par	y,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 28 Tina Louise Gordon 2011 11:55 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro 12400 Farm Road Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 X **Director** 212 80 8141 46 Mary Land 28 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Maryland Prince George's Upper Marlboro 1 Yes 2XX No 10e. Street and Number 10g. Citizen of What Country? Funeral 12400 Farm Road 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced **Black** Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Tech legal. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard C. Waters Shirley Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora D. Kimes (Sister) 9808 Larsen Place, Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/4/2012 Suitland, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnat Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day g Unknown ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page 2 No Yes 2 🖵 1 🗌 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

BQ-3
State
Registrar

30. Name and address of person

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Jean Huntley 1029 December 2011 Medical 4a. Facility Name (if not institution, give street and put 4b. City. Town, or Location of Death Examiner 4c. County of Death • HICOMICO BIONAL SALISBUIL Redical 7. Age (In yrs. last birthday) If Under Year If Under 24 H 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 219-44-2003 **Director** 1 □ M 2 🕱 F Jan 28, 1947 MD 64 Usual Residence of Decede 28a-f show 10a. State with the Maryland Examiner must be notified at 10b. County 10c City Town or Location 10d. Inside City Limits Director Delmar 1 XYes 2 No MD Wicomico 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral 23a 408 S. Maryland Avenue 21875 USA items 2 death v Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Lvc. Armed Forces? 1 ☐ Yes 2 🙀 No Black White etc þ 1 X Never Married 2 Married 'natural", or 72 hours after Baltimore, Maryland 21215-0036 African-If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Laborer Nursery and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Huntley Mandy Lee Jenkins and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 408 S. Maryland Avenue, Delmar, MD 21875 Melody McCarthy/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 1/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park Salisbury, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson 1618 West Rd., Funeral Home, PA Salisbury, MD 21801 alsor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Month Day Year Pregnant at time of death be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? after death.

| Director: After this certificate | Yes 2 X No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury work 1 Yes filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State To the Hospital or within 24 hours at To the Funeral D Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur

State Registrar 1665 KOODBrook

Salisbury Mo

erson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

BAIG

JAN09

Date filed (Month, Day, Year)

11.0

State of Maryland / Department of Health and Mental Hygiene 43530 State
Registra Ameno 23a. Prt 1 POPer Phys. 1-9-12cr Certificate of Death 2. Date of Death Physician/ 4:16 P M Geraldine J. Hooks December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Days Hours Min Country) D.C 1 □ M 2 😿 F 579-50-9954 72 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington D.C. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 1430 W Street, NW., Apt.#31 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specif African-American "natural", 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Private 12 Personal Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Hooks Margaret King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6706 Central Hill Terrace, Landover, MD 20785 Ann Hooks-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 5, 2012 Washington, D.C. Glenwood Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 21. Signature of uneral Service Licensee lll Part 1. He ter the dise of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ rdopulmony disease or condition Medical resulting in death) Examiner ultinger Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami and -transit death certificate be executed Ventricular Arrythmia Due to (or as a consequence of). resulting in death) Last burial-Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 1 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 \square Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending s after death.

I Director, Aff 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lylla Shahab 7600 Carroll Ave Takona Park State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.0.

11-09857 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Luther Russell Huffman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Luther Russell Huffman Month Day December 31, 2011 0810 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3155 Marbury Run Road Marbury Charles **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Director Months Days Country Hours 219-86-5849 1 X M 2 F 49 Yrs June 2, 1962 Washington DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No hours after death with the Maryland Maryland Charles Director Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5695 New Cut Road 20658 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. the Medical Examiner must be 14. Race - American Indian, Black, 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 9 Yes Widowed 4 X Divorced If Yes, Giva Year 1 Yes 2 X No specify. <u></u> Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Franti. Pages I and 2 should be filed within 72 lparament of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 10 Fence Installer Fence Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Luther Richard Huffman Catherine A. Sydnor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luther R. Huffman Father 5695 New Cut Rd., Marbury, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Jan. 5 2012 Donation 5 Other Specify. Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral S 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd. Indian Head Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line /Medical Between Onset and a. Multiple Injuries Immediate Cause (Final disease Examiner Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical ned by the attending physician detached for use as the burial UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth past 12 months? Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≨ 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 Other₄ 1 🗸 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Dec 30, 2011 (ear) e Funeral Director: A Natural UNKNOWN Subject assaulted Pending

Division of Vital Records, P.O. Box 68760, e Hospital or Attending Physician: 124 hours after death.

State

Carol Allan, MD Assistant Medical Examiner 31. Date filed Month 32. Registrar's Signature

29b. Signature and title of certifier

2

3

Medical

Accident

Suicide

4 V Homicide

29a. Certifier 1

Investigation

determined

6 Could not be

0°6°2012

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 ✔ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 3155 Marbury Run Road, Marbury, MD

O.C.M.E. January 1, 2012

30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223

(Specify) Residence

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Registra

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Myrtle Hall Hurdle Medical 201 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death KEGIONAL MEDICAL 44156414 PENINSULA HICUMICS If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Month 87 215-12-6572 $^{
m o}_{
m untry}$ Director 3-29-1924 1 🗆 M 2 🔀 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Salisbury Wicomico MD 10e. Street and Numbe 10g. Citizen of What Country? ö 10f. Zip Code items 23a or ner must be r Funeral USA 21801 Mallard Landing #203 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married 1 Yes 21 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify white Specify "natural". Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Florist 12 event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic even မ Elizabeth Annie Clark Raymond William Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other tra Mt. Olive Road Salisbury, MD 21804 <u>Linda H. Gardne</u>r-Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State First State Crem. 1-2-12 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service I 21. Signature 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ INTACRANIAL HEMORHAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown Day detached 1 ☐ Yes 2 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform after death.

Director: After this certificate Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မြ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti

Registrar

DHMH 17 Rev 06-2011

State

parke

completed cause of death (Item 23a) (Type, Print)

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JAN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVI	aryland / Depa			/lental Hy	giene		10500
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	Death		Reg. No. 2	Щ	43533
п	Physicia		Susie A. Holzwart				2. Date of De Month	Dav	Year	3. Time of Death
Diego	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	Dec 30,	4c. County	of Death	7:09 P M
المموس	The state of the s		Washington Adventist Hospita	1	Tacoma		Monte			
1	Funeral			e (In yrs. last birthday)	If Under 1 Year Months Days					place (State or Foreign
E.	Director		578 22 9850 1 ☐ M 2 🗓 F Usual Residence of Decedent	95 Yrs.			Oct 9, 1			ion, MD
	and show	ē	10a. State 10b. County	10c. City, Town or Loc	cation	1			1	0d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Prince George's	Takoma	a Park					1 🗌 Yes 2 🔀 No
	h the		10e. Street and Number		10f. Zip Code	210		10g. Citizen of		·
	ns 200	Funeral	7207 16th Ave			912	7 17 11	United		
	er dez or ite niner	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	J H	Yas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)		e - Americ ck, White, e	
, 03	ırs aftı ural", [Exar	ed k	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates.	1	Yes 2 No	Specify:		Specify	Whi	.te
<u>.</u>	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give A	lent's Usual Occupa kind of work done d	ation Juning most of worki	ing	16b. Kind of B	usiness/Ind	Justry
12	ithin 7 ene. r than the M	Con	Elementary/Secondary (0-12) College (1-4 or 5)+)	1 NOT use retired) 1 les Clerk			Sea	rs	
pg ;	Hyg othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,			
/lar	d be f Venta arked itic ev	오	Norval Fulton Tippett			Hattie	Virginia	Hutchinso	n	
Maryland 21215-0036	shoul and l is ma		19a. Informant's Name/Relationship (Type, Print)		-	and Number or Rura				1
é .	and 2 Health Sm 27 Sher tr		John P. Holzwart (Son)			bia Pike #3				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	1	natory or other place	e)	Date	20c. Location		
iti.	nit. Pa antme ortan injun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee	Fort Lincol		1/6/2		Brentwo		
m	Depar Impor any in		Messeca (mozo	Q Fe	erry Road, (Clinton, MD	20735	Home, Inc	6633 C	old Alexandria
	>		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	r the mode of dying	g, such as cardiac c	r respiratory arr	rest,		Approximate Interval Between
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		Jer	Sequentially list conditions,	RATUS -	Faile	re_			-	
7	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	A	ure					
Z Z	exection and initial-tr	E	that initiated events resulting in death) Last	a consequence of);						
Box 68760	icate be executed physician and as the burial-transit	edical	d			<u>-</u>				
687	ding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy						
Box 68760	attending p	Physician/M	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)	У			te of delive onth	ery Day Year
B .	been signed by the should be detached	hysi	1 Yes 2 16 4 Pregnant a 9 Unknown							
O	yned k		Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
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000	naw has be	Completed by					24a. Was a autop	osy	prior to cor	osy findings available npletion of cause of
֟֟֟֟֝֟֟֝֟֟	certificate has blirector, page 2 s		25. Was seen valoused to modical				1 \(\text{Yes}		death? 1 Yes	2 🗆 No
/ita	r this certifica aral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:		Otha	r:				
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on	eath. or: Aft	fical	1 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation	; Year) injury	M 1 □	? Yes 2□No				
Division of Vital Records,	a after death. Director: After the in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubuilding, etc	ry - At home, farm, stre . (Spec <i>ify</i>)	et, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
	ours a		29a. Certifier Certifying Physician: To the best of	my knowledge, doeth o	accurred at the time	data and place as	d due to the ca	useds) and man	or ac etata	la l
H	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	amination and/or investi	gation, in my opinior	n, death occurred at	the time, date a	nd place, and due	e to the cau	se(s) and manner stated.
T C	withi To th		29b. Signature and title of certifier		29c. License			29d. Date signed		
			Kandl / Wyn	- MD	449	57		Decem	ber ?	30,2011
B	a-5		30. Name and address of person who completed cause of de			A 1791 4		D 00055		
	Stat	e	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	u carroll	Ave, Takoma	Park, M	D 20912		
	Registra		JAN 0 3 2012	flow	un B.	par				

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			For State C	of Maryland / Depa	artment of H tificate of D		lental Hygie	ene 20	1.1	43534
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Tillcate of L	<i>Death</i>	Reg 2. Date of Death	J. No. 2 U	- 1	3. Time of Death
*	Physicia Medi		Charlene H. Hockenberr	у			December	[□] 2 ³ 9, 20	i i i	8:49 A M
	Examir	ner	4a. Facility Name (if not institution, give street and num			Location of Death		4c. County of (.1.1
	Funeral		Anne Arundel Medical Ce 5. Social Security Number 6. Sex	nter 7. Age (In yrs. last birthday)	Annapol If Under 1 Year	L1S If Under 24 Hrs.	8. Date of Birth	Anne		ace (State or Foreign
a.	Director		579-18-4036 1□M2戻F	91 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 7/2/1920	ear)	Countr	nigan
	and show Lat	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		., _,		_	d. Inside City Limits
	Maryl. 28a-f otified	irect	Maryland Anne Arundel		An	napolis				1 ☐ Yes 2 🛣 No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 868 Clubhouse Village	View	10f. Zip Code	21401	109	g. Citizen of Wha	t Counti	y? USA
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 1 Yes	rces? If	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:		c.
2-0	2 hour "natul edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa aind of work done du		16	b. Kind of Busin	ess/Indu	ıstry
21215-0036	ithin 7 iene. r than the Me	Com	Elementary/Secondary (0-12) College (1-	4 or 5+) life. DO	MOT use retired)	aring most or work.	'g	Own H	ome	
land 2	I be filed w fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Lewis Mason				e (First, Middle, Maid e Snedike	den Surname)		
Baltimore, Maryland	d 2 should alth and M 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Stuart Moisan - Nephew	19b. Mailin 136	g Address (Street ar East Lake	nd Number or Rura E Dr, Ann	Route Number, Cit apolis, M	ty or Town State ID 21403	, Zip Ca	de)
more	Page 1 an nent of He int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State 20b. Place of Dispose cemetery, creme Parklawn	natory or other place	9)	20 1/2011 R	c. Location - City		
Balti	permit. Pepartm Departm Importa any inju		21. Signature of Funeral Service Licensee	22.	Name and Address 47 Duke of	s of Facility Jo	hn M. Tay	lor Fun	era]	Home
r		Т	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea	aused the death. Do not ente				Alliapoi		Approximate
-	Ph_sician/		Immediate Cause (Final disease or condition	1 12/mminor	a Doma	_				nterval Between Onset and Death
Series of the Se	Medical Examiner		resulting in death) Due to	or as a consequence of):	~ H	Si .				
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.	or as a consequence of):						
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9/89	certificate	Med	IF FEMALE:							
, B0	death ne atte ed for	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of Month		/ ay Year
	that the ned by ti	by PI	Part II. Other significant conditions contributing to de	ath but not resulting in the un	nderlying cause give	en in Part I.	23e. Did tobac	co use contribut	e to the	cause of death?
rds,	law requires nas been sign e 2 should be	ted	HIN				1 🗌 Yes	2 □ No 3 □	Proba	bly 4 Unknown
Ž.	The law ate has page 2	Completed					24a. Was an autopsy performed	prior	to comp	y findings available bletion of cause of
<u> </u>	ician: certific rector,	Be	25. Was case referred to medical examiner? Hospital:		26. Plac	ce of Death (Check				
01 <	al this	e: To	27. Manner of Death 28a. Date of		28c. Injury a	4 ☐ Nursing Hor	ne 5 Residence 8d. Describe how in		pecify)	
0	eath. or: Afti the fur	Certificate:	1 Natural 5 Pending (Month 2 Accident Investigation 3 Suicide 6 Could not be	n, <i>Day</i> , Year) injury	M 1 □ Y	es 2□No				
DIVISION	tal or Attras after d al Direct led in by		4 Homicide determined 28e. Place	of Injury - At home, farm, stree g, etc. <i>(Specify)</i>	et, factory, office	2	8f. Location (Street City or Town, St		Rural R	oute Number,
	To the Hospital or Attending Physician: To the Funeral Director. After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the be (Check only one) 3 Certifying Nurse Practitioner:	s of examination and/or investig	gation, in my opinion	, death occurred at	he time, date and pl	ace, and due to the	he cause	e(s) and manner stated. ted.
	Vith vith Com		29b. Signature and title of certifier		29c. License r	number	29d.	Date signed (Mo	,	v, Year)
	,		30. Name and address of person who completed cause	of death (Item 23a) (Type Pr	int)	418/6			30	///
	126		30. Name and address of person who completed cause Charles W. Phen A. D. 31. Date filed (Month, Day, Year), 5 2012 32. Re JAN 0 5 2012	139 0/0 50	Timens Is	lone Rd.	, Annop	olis m	0	21401
	Stat Registra	e Ir	JAN 0 5 2012	known B. A	back		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 43535 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 28, 2011 Margaret Elizabeth Hodges 10:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 4505 Greenwood Road Beltsville Prince George If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 577-07-6378 1 🗆 M 2 😿 F 94 06/10/1917 Washington, DC Usual Residence of Deced show 10a. State notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 😾 No Maryland Anne Arundal Davidsonville ms 23a or must be n 10e. Street and Number 10g. Citizen of What Country? Funeral 2503 Doyles Lane 21035 U.S.A. items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If flem 27 is marked other #--- any injury or other traumant. 14. Race - American Indian, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Dept. of Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ John F. Mahaney Pearle A. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Doyles Lane Davidsonville, MD 21035 Richard Hodges/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 01/07/2012 Brentwood, MD Signature of Funeral Service Ucensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 use as ding F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? ☐ Pregnant at time of death ☐ Unknown the 1 Yes 2 to 9 Unknown P.O. signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autonsy perform death? certificate 1 🗌 Yes 2 🗆 No 1 Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Granddaughter Residence Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to ad in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurs Prectitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R12

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Items State Registrar	23 State of M	arylan 23,2	d /28epa Cer	rtment of H f per me tificate of L	lealth ar 9923 , ()eath	od Mental Hy	giene dhb 2	011	43536
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Jan	Medio Examin		4a. Facility Name (if not institution, giv	e street and number)		1	4b. City, Town, or	Location of I	Death	4c. Cour	7.0() nty of Death	101:00
	Funeral		5. Social Security Number 6		e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24				place (State or Foreign
	Director		238-20-2133 Usual Residence of Decedent	1 □ M 2 X F	87	Yrs.	Months Days	Hours	Min. (Month, Da		Wes	t Virginia
	yland -f show ed at	ctor	10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits
	the Mar or 28a e notifi	Director	MD Howard 10e. Street and Number		E11	kridge	10f. Zip Code			10g. Citizen o	of What Cour	1 Yes 2 No
	ns 23a must b	Funeral	5735 Rowanberry				21075			USA		
900	s filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Š	11. Marital Status 1 □ Never Married 2 🏋 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		l'	Vas Decedent of His Yes, specify Cubar	n, Mexican, F	(? (Specify Yes or No- Puerto Rican, etc.)		Race - Americ Black, White, Fify: Whi	etc.
21215-0036	iin 72 hou ie. han "nat i e Medica	Completed	15. Decedent's (Specify only highest g		i+)	(Give I	lent's Usual Occupa kind of work done do NOT use retired)		f working		f Business/In	
d 21	filed within all Hygiene.	Be	12 17. Father's Name (First, Middle, Last)			Scret	ary	18. Mother's	s Name (First, Middle,		al Sec	urity
Maryland	ould be file nd Mental I marked o imatic eve	욘	Alexander Billip					Lydia	a Elizabet	h Beave	ers	
	Ith ar Ith ar 27 is r trau		19a. Informant's Name/Relationship (Pepper Watkins Mi		hter				or Rural Route Numbe Elkridge M			
altimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🖟 4 🗀 Donation 5 🗀 Other (Spec		- C	emetery, cren dowrid		rdenNo	Date ov.18,2011	Elkric		aryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licer	Sea	9				Ambrose Fur			nc. 1and 21227
	MATERIAL PROPERTY.		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line	the death		r the mode of dying	, such as ca				Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequ	MAN () lence of):	my tai	lune			-	
		iner	Sequentially list conditions, if any, leading to immediate	b. Aut	a consequ	ence of): ∇	failWe entillato	r Asso	ociated Pn	eumonia	a	of JRyanic
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Box 687	certific nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗌 Feta	Ideath 3	Ectopic pregnancy	/	CERTIFICATION APPR	WED & LEG	ate of deliver	ery Day Year
P.O. B	at the de d by the letachec		9 Unknown Part II. Other significant conditions	9 Unknown	ut not resi	ulting in the u	nderlying cause give				entribute to th	ne cause of death?
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ecor		Completed	and sick s	inus cyh	gron		Cardiomyo		24a. Was autor		b. Were auto prior to co death?	psy findings available mpletion of cause of
a B	sician: The certificate h irector, page	Be Co	25. Was case referred to medical	C nip	ma	cture	26. Pla	ce of Death	1 ☐ Yes (Check only one)		1 Yes	2 X No
of Vit	Physic r this ce eral dire	မ	examiner? 1 X Yes 2 X No 27. Manner of Death	Hospital: 1 Ninpation 28a. Date of inju		ER/Outpatien	t 3 DOA Othe	4 □ Nursi	ing Home 5 Resid)
ion	I or Attending after death. Director: After d in by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	May 4,2	(, Year)	injury Unkno	a. work?	Yes 2 X N	Subjec	t fell	out o	of a
Division of Vital Records,	tal or At s after d al Direct ed in by		4 Homicide determined				et, factory, office		28f. Location (S City or Tow Drive ,	Street and Num on, State) 5 Elkrid	nber or Rural 735 Ro ge,MD	Route Number, wanberry
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Exam	vsician: To the best of niner: On the basis of e	xamination	and/or invest	igation, in my opinioi	n, death occu	ace, and due to the ca	ause(s) and ma ind place, and	anner as stated	use(s) and manner stated.
	To the within comments of the	-	29b. Signature and fittle of certifier	MIN			29c, License	number 0643	_	29d. Date sign	ned (Month,	Day, Year)
		co de	30 Name and address of person who OKey	completed cause of de	eath (Item	23a) (Type, P	al mak)		en Street	Rally		MD 2171
	Stat Registra	e	31. Date filed (Month, Day, Year) JAN 2 4 2012	. Registra	ar's Signat	bark		J. 014	CNI JIIWI	1 DAVITA	ו שועאי	TIO VILUI
			Attitue a de la	Markon	10.	7 000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1-For State Registrar Certificate of Death Reg. No. 201	1 4353
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death
Higureal Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	University Boulevard and Langley Dr Silver Spring Montgomery	
Funeral Director		rthplace (State or gn West Indies ^{Duntry)} Jamaica
any	Usual Residence of Decedent 10a. State	10d. Inside City Limits
Aaryland 28a-f show Lat once.	Maryland Prince Georges Hyattsville	1 X Yes 2 No
the Maryland a or 28a-f she tiffied at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou	intry?
with the cotification of all D	11 Marital Status 12 Was Decedant Ever in U.S. 142 Was Decedant of Viscosia Octain O. Occió Verna No. 144 Decedant	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Never Married 2 Married 2 Married 2 X No Married 2 X No	ican Indian, Black,
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5-0036 led within 72 hours after Hygiene. I other than "natural", the Medical Examiner. Completed by I		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	12th grade High School Student County Pub	lic Schools
Hygie Worther Worther Market		
21215-0036 oald be filed within 7 d Mental Hygiene. s marked other than tic event, the Medical TO Be Comple		Zio Codo)
and 2 shorten 27 is transmitted	Claudia Elaine Morris (Mother) 7304 Riggs Road; Apt. 107; Hyattsville, Ma	- 13
ages I and in of Heal it: If item other tra	20a. Method of Disposition 1 \(\begin{array}{c} \text{20a. Method of Disposition} \\ \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \\ \text{Date} \\ \text{Jan.7,2012} \end{array} \] 20b. Place of Disposition (Name of cemetery, crematory or other place)} \\ \text{Date} \\ \text{Jan.7,2012} \end{array} \]	Town, State
Baltimore, Permit. Pages I ar Permit. Pages I ar Perpartment of Her Important: If ite	4 Donation 5 Other Specify. George Washington Cemetery Adelphi.	faryland
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Serice Licensee 22. Name and Address of Facility R. N. Horton Company	Morticians,
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	Between Onset and Death
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x 68760, th certificate be executed trending physician and r use as the burial - transit cician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the	
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). Box the death by the atte	1 Yes 2 No 9 V Unknown	
P. S. that s that deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1	
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ecol he law te has ige 2 st	performed? death?	completion of cause of
ital Recition: The certificate rector, page	25. Was case referred to medical 26. Place of Death (Check only one)	s 2 No
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C # 1 ~ 4 7	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Passenger auto-fixed objects of	collision
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Division To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the Hedical Certificati	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	e cause(s)
Tot with Tot com	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo)	
	O.C.M.E. December 30, 20	
o u	30. Name and address of person who completed cause of death (Item 23a)	
C T	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Robert Henry Jenkins 742 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days 218-14-3686 1 X M 2 □ F 88 Usual Residence of Decedent Sept.21,1921 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Calvert Owings 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 879 Fowler Road 20736 USA 12. Was Decedent Ever in U.S. Armed Forces 1 September 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Jenkins Emma Jane Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 307 Owings, MD 20736 Ann Jenkins /daughter 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 4 \square Donation 5 \square Other (Specify) 1/6/2012 Patuxent UMC Cem Huntingtown, MD of Funeral Service Lic 22. Name and Address of FacilitySewell Funeral Home 1451 Dares Beach Rd., Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions nediate Due 1 ilig jury 40 ancer 05ta Due to (or as a consequence of):

Ph sician/ Medical Examiner and

Physician/

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28a-f show

ms 23a or 28a-f sho must be notified at

items

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of Health and Mental Hygiene.
If item 27 is marked other tha

Department of Health Important: If item 2; any injury or other toonce.

Director

Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Medical Cer

To the Hospital or Attending Physician: The law requires that the death certificate be

hours after death. Ineral Director: After this

within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760

Examin	Cause (Disease or in that initiated events resulting in death) La
ysician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown
pleted by Phy	Part II. Other signific
To Be Com	25. Was case referred examiner? 1 \sum Yes 2 \textit{Yes}
ificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide

29b. Signature and Itle of certifier

. Date filed (Month, Day,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Check on Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other; 4 ☐ Nursing Home	1 Yes 2 2 No 1 Yes 2 No 1/2 No 1/
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? on M 1 □ Yes 2 □ No	e 5 Residence 6 Other (Specify) d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		if, Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 \(\sumeq\) Medical Exa	ysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place Practitioner: To the best of my knowledge, death occurred at the time, date and place	e time, date and place, and due to the cause(s) and manner state

29c. License number

D0053539

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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eleted cause of death (Item 23a) (Type, Prin

32. Registr

201 East

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Osmund I. <u>Johnson</u> Medical 11 10:340 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7703 Old Barn Rd Prince George If Under 1 Year If Under 24 Hrs. Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Days **Director** 215-70-8642 54 1 XM 2 □ F 1-23-1957 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marting a once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No Maryland Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7703 Old Barn Rd 20715 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2X No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Prince George Co. Teacher Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lavette Johnson Ruth Coston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Johnson-Brother 11100 Pompey Dr. Upper Marlboro MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Shiloh Ch Cem 12-31-11 Pocomoke 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ecta disease or condition unknown Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-trai Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certification

Registrar

DHMH 17 Rev 06-2011

9200 BASIL CT

Registrar's Signature

STE 200

LARGO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IPPMAN

11-09827 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Terry Lee Jones, Jr. State of Maryland / Department of Health and Mental Hygiene 2011 43540 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month **Medical Examiner** Terry Lee Jones, Jr. December 30, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1200 block Patuxent Road Crofton Anne Arundel 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** oreign Maryland Months Days Min Director Hours 458-43-7435 49 08/25/1962 1 X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County MD Gambrills Anne Arundel or 28a-f show Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 722 Cyprian Court Funeral 11. Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? White, etc. Yes White 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 No specify: 6 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Information Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Technology 5+ 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Beverly Welch 8 Terry Lee Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 Cyprian Court Gambrills, MD 21054 Tammy Jones / Wife ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Jan. 07, 1 Burial 2 Cremation 3 Removal from State Department of Important: I injury or other Metro Crematory, INC. Baltimore. MD 2012 4 Donation 5 Other Specify: 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy. Severna Park, 23a. Part . Enter no disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medical failure. List only one cause on each line a Sharp Force Injuries of the Neck and Right Wrist Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last tending physician and use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ficate has been signed by the att , page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 sl performed death? 1 🗸 Yes Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) å Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury FOUND: FOUND 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject cut and stabbed self 1 Natural FOUND 5 Pending 1 Yes 2 V No within 24 hours after death.

To the Funeral Director: the Dec 30, 2011 1330 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1200 block Patuxent Road, Crofton, MD (Specify) Woods Homicide 29a. Certifier (Check only completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

3 Time of Death

1330 hrs

10d, Inside City Limits

1 Yes 2 No

MD 21146

Day

29d. Date signed (Month, Day, Year)

December 31, 2011

Approximate Interval

Between Onset and Death

Year

2 No

Registrar

32. Registrar's Signature

and manner stated

1.48

State

29c. License number

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and little of certifie

Victor Weedn MD JD

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis Wilson Dec Jerman Sr 201^{Year} 29 5:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1501 Kempa Ct Upper Marlboro Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Hours (Month, Day, Year) av 3 1958 Director 53 216-76-1379 Usual Residence of Decedent 28a-f shov 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Upper Marlboro Md 1X Yes 2 No ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1501 Kempa Ct 20774 U.S.A. 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygle Important: If item 27 is marked other i any injury or other traumatic event, th System Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilson R. Jerman Gladys Edmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denesa Scales Jerman -Wife 1501 Kempa Ct Upper Marlboro Md 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation Ft Lincoln Cem 1-7-2012 Brentwood Md 4 Donation 5 Donation Other (Specify) Signature of Funeral Service Liounsee 22. Name and Address of Facility McLaughlin Funeral Home 2518 Pennsylvania Ave SE Wash DC 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death

Months Physician/ Metastatic adeno carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 2X No 1 🔲 Yes Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending veral Director: A filled in by the f ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year) D0068604 January 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 Old Branch Ave # 202 RAZIE MD Clinton, 20735 State 32 Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 3,24a per dr.,g923,01/14/2012dhb

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1425 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis foundatista rdausto mSocial Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) unk **Funeral** 8. Date of Birth (Month, Day, 1 □ M 2 🗓 F Hours Director 097-40-9364 61 Jan Usual Residence of Decedent or 28a-f show notified at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral 601 S. Charles St; Apt 4A 21230 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? unk
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk of Health and Mental H If item 27 is marked of r other traumatic ever မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other trai Gary Cox - nephew 5612 Haddon Ave; Apt A; Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state Department o Important: If any injury or Signature of Funeral Section Roperid S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physicin disease or condition resulting in death) Medical Due to (or as a consequer e of): **Examiner** temente Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Diabeto burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy death? hroug this certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ဂ္ဂ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 71493 11-2-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 17 per fh 9923 1-27-12 vt/ #20b.perFH.G924,2/7/2012,WS 4 3 5 4 3 State of Maryland / Department of Health and Mental Hygiene 2 () | 3 5 4 3 1 - State amend item 15 per fh g923 1-27-12 vt. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} MARILYN BERNADETTE KYLE 2011 3:15 DEC Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WRNMMC BETHESDA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 1 - M 2/X F Months Days Hours Min 523 98 9451 55 Director July Mary land Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4601 Calais Street 20745 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 V Yes 2 D Netive
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 😾 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical and so the present than any injury or other traumatic event, the Medical and so the present than any injury or other traumatic event, the Medical and any injury or other traumatic event, the Medical and any injury or other traumatic event, the medical and the present that the present the present that the present that the present that the present that the present the present the present that the present that the present that the present the present the present that the present that the present that the present the pres 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Chief Master Sgt U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John B, Conwell Shari L. Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A Kyle, Jr. (husband) 4601 Calais Street, Oxon Hill, MD 20745 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date 7. cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Arlington National Cemeterly Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licens O Upa Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): ysician and e burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical phys; attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent oregnant 23d. Date of delivery in the past 12 months? Dav Year Yes 2 XNo 9 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No Yes 2. √ No 25. Was case referred to medical funeral director, a 26. Place of Death (Check only one) examiner? 2 XNo Hospital Other: 1 🗌 Yes ျ 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination arrow investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 10+1,1A VA 0101244127 MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRNMMC, BETHESDA, MD 20889 5600 A WEBER. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State JAN 0 3 2012 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 43544 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1:21 AM KEMP 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cerroll Carroll Westminster Huspital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 😿 F 219-56-7456 97 **Director** Oct. 4. 1914 N. Carolina Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Maryland Hampstead 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4716 Mount Carmel Road 21074 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Lydia Letterman Isaac McInturff permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Linda L. Edwards / daughter 10 Marlborough Court New Castle, DE 19720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 3, 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland 2012 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Esophujent Stricture , Congestive Heart Failure To the Hospital or Attending Physician: The law requires No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Typertenilar, Diwhetter Type Z, Panyaysmal A. Poh 24a. Was an autopsy performed? Yes 2 No a-tuhe 25. Was case referred to medical examiner? 26 Place of Death (Check only one) 1 Yes No Other: ျှ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 ☐ Yes 2 ☐ No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕰 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MM Decembe 29,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Avenue Hornstal Center CHINTW SHARMA MD 21157 Curroll MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2012

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Dark

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Jung Ae Kim 2011 Dec. 28. 0332 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 493-82-9233 Director 79 1 🗆 M 2 🗶 F Aug. 20, 1932 Korea 28a-f shov 10a, State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director PA Montgomery Collegeville 1 Yes 2 X No 10f. Zip Code 10e. Street and Number ö 10g. Citizen of What Country? items 23a Funeral 1201 East Autumn Ct. 19426 Korea 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc . 0. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Hygiene. other than "natural", Specify: Asian 3 X Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker should be filed with and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown So Im Hwang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. 1201 East Autumn Ct., Collegeville, PA 19426 Byung Kim/Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 31, 1 🗆 Burial 2 🔀 Cremation 3 🔀 Removal from State Fairfax Memorial Dec. Fairfax, VA 4 Donation 5 Other (Specify) Funera 2011 Home Fairfax Memorial Funeral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, 9902 Braddock Rd., Fairfax, VA 40423 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Sepsis resulting in death) Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 3 To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Dav Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed 1 ☐ Yes 2 ☐ No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 62/28/11 068912 agunas ess of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLENRO., SILVERSPRING, MD 20910 Laguns - Tita 31. Date filed (Month, Day, Year) JAN 05 201 Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	meral Service Lice	ensee Mc, L	2						1 Ho	me In	ç.	MD 20901
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, pag.	Medical	(Check 2	2 Medical Exa	mysician: To the best miner: On the basis o urse Practitioner: To	of examination	n and/or invest	igation, in my opinio	on, death occ	curred at	the time, date a	and place	, and due to	the cause	
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16		D. 1.	3. She	rman			D528	32			J	Januar	y 4,	2012
			ress of person wh	o completed cause on MD 1	of death (Item 396 Pi	23a) (Type, F .ccard	Drive, R	ockvi	11e,	MD 208	350			
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Registra	ar	J	AN U5 2	UIZ Store	un p	1. pa								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D30, 2011 Earl Kenneth Lookingbill December 3:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 48 Memorial Drive Taneytown Carroll 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days 1 XM 2 🗆 F Hours Jan 7, 1935 Maryland Director 215-32-1487 Yrs 76 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified Maryland Carroll Taneytown 1 XYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 48 Memorial Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? 1 X Yes 2 □ No 1957-If Yes, Give 1050 Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced white Completed 1959 Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Firefighter traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည George Lookingbill Edna Legore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lookingbill, wife 48 Memorial Drive, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. cemetery, crematory or other place. ■ Burial 2 □ Cremation 3 □ Removal from State Trinity Lutheran Cem 01/04/2012 Taneytown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heck, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Acute KesniraToru disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) by the attending physician and tached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Year Pregnant at time of death Day 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has erformed death? this certificate Yes 2 No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 □No 1 Tes Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 039502 40 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Division of Vital Records,	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, o	office	28f. Location City or To		nd Number or Rura e)	al Route Numbe	θ <i>Γ</i> ,
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	347		30. Name and address of person who co	mpleted cause of death fiter	п 23а) (Туре,	0	· Kid	2185	- /			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ December Charles Edward Mackall 4:21 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-32-9557 Director 1 X M 2 □ F 76 May 27,1935 MD Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's 1 Tes 2 X No Mitchellville 10e Street and Number ō 10g. Citizen of What Country? Funeral USA 10909 Kencrest Drive 20721 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 11 Heavy Equipment Oper. Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Mackall Frederick R. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hawkins-Arthur/sister 10909 Kencrest Dr.,Mitchellville,MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moses Cemetery 1/11/2012 Lothian, MD 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd.,Prince Fred.,MD20678 21. Sign ture of Funeral Sep Hoshen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of Interval Between Immediate Cause (Final Onset and Death .Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsi 1 Yes 2 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Tyes 2 No Hospital 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 1/etember 30 2011 72075 30. Name and address of p son who completed cause of death (Itam 23a) (Type, Print) PR. Soty Lanham MD. 20706

Registrar

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State #26, 01/03/12 Per Physiciar Certificate of Death D.H. WCHD I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a Bay adygai William Calvin McCoubrey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c, County of Death 1 Hos Salisbur Vicomico asta Cel If Under 1 Year If Under 24 Frs. Funeral 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ F Days 216-12-7086 88 1077/1923 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MD Worcester Whaleyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 8804 Peerless Rd. USA 21872 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by MX Yes 2 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates. Navy injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Fire Chief Ocean Pines Fire Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert H. McCoubrey Charlotta Matilda Baquol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Linda McCoubrey (wife) 8804 Peerless Rd. Whaleyville, MD 21872 mportant: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sunset Mem. Park Jan. 2, 2012 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD 21811 108 William St. 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day 2 No signed by the a d be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been signe rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed' Yes 2 No 1 \sum Yes 25. Was case referred to nedical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Mann of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 🗓 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBREDRY SAUSIBURY 910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 25 per med cert 6930 8/30/12 dk

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Reg. No. 20 43551 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28, 20^{rea}1 December 7:40A Helen Margaret Mitchell Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Cedar Tree Assisted Living Waldorf Charles Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F Months Min. November 3, 1922 Virginia 228-18-1794 89 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified MD St. Mary's Mechanicsville 1 Yes 2 No 10f. Zip Code 20659 9 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be 30165 Huntt Road Funeral death v 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 12 Book Keeper Heating & Oil Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Addie Hill Clinton George Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Holmberg/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hill Crest Cemetery 12/30/11 Louisa, VA 4 ☐ Donation 5 ☐ Other (Specify) M00945 any in 21. Signature of Funeral Service Licensee ²²AREHART ECHULS FUNERAL HOME, P.A. 20646 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORDINARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on -transit death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial-Physician/Medical Box 68760 ast IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 W No Pregnant at time of death the Unknown 9 Unknown P.O. | Hospital or Attending Physician: The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 6 Nother (Specify) Hospital 1 Yes 2 XNo Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work?
1 Yes 2 No 5 Pending after death. 2 Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Funeral L Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D42509 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH MP MERNOLPI 12070 OLDLINE CHE HIOD WARDORF 31. Date filed (Month, Day, Year) 2. Registrar's Signature JAN 0 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#3 per PHY State of Mary 1 = For American American State of Mary Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 24 Helena R. Mays December 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 2:30am 4c. County of Death Heritage Harbour Health & Rehab Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 8 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours 217-26-1608 **Director** 1 □ M 2 **X** F 1928 83 Yrs. Maryland with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Mary1and Anne Arundel Annapolis 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be r Funeral 57 Spa Rd. 21401 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify "natural", Completed Black 3 ▼ Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12th 2yrs Security Guard State of Maryland Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Clayton Savoy Sr. Carrie Crowner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Harry G. Reese(Brother) 1922 Forest Dr. Annapolis, Md. 21401 other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. ò Crownsville, Md. Maryland Veteran | 1-3-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Almane a Receise Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ enal 10 disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** mias Sequentially list conditions cause. Enter Underlying Cause (Disease or injury uence of) the burial-transit Physician: The law requires that the death certificate be executed om that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Sease Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day detached 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?

Yes 2 No certificate 1 Yes 2 No funeral director, Be Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after deaun.

Funeral Director: After this of the funeral diplication by the funeral diplication. 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200706 171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED MAHBOOB Suit boli 31. Date filed (Month, Day, Year) gistrar's Signature State JAN 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar 43553 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lawrence Charles Mawn December 2011 15:17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number 088–34–5970 If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 1 🕅 M 2 🗆 F 68 07/29/1943 Usual Residence of Decede New York 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Anne Arundel Annapolis X☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 Moss Haven Court 21403 United States items ? Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. That if item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Wildowed 4 Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner/CEO 5+ Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Francis Mawn Rose McGuire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Moss Haven Court, Annapolis, MD 21403 Mary Ann Mawn/Wife 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of once. St. Mary's Cemetery 01/09/2012|Annapolis, Maryland 4 Donation 5 Other (Specify) . Signatur of Funeral Service Livenses 22. Name and Address of Facility George P. Kalas Funeral Home ales 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence with **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 2 🗆 No Yes Yes 2 N To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signate 29d. Date signed (Month, Day, Year, D0005829

State Registrar Howard

Anne Avande

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 05 2012

MO

11-09828

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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rederick Willia	m M	1- For State Certifica:	nt of Health and Mental F te of Death	Reg. No	
Physic Medical Exam				2. Date of Death Month December 30,	3. Time of Death
,		Frederick William Myers, Jr 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
		11601 Ash Road Suite A	Beltsville		Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24Hr Months Days Hours Min		M/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary1ar
nd show any		Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Belts:			10d. Inside City Limits
ith the Maryland 23a or 28a-f sbo notified at once.	Director	10e. Street and Number 11601 Ash Road Ste A	10f. Zip Code 20705	10g. C	itizen of What Country?
215-0036 be filed within 72 hours after death with the Maryland stal Hyggene. **Red other than "austural", or items 23a or 28a-f sho ent, the Medical Examiner must be nofffed at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
s after ral", o	þ	3 Widowed 4 Divorced If Yes, Glve Year or Dates:	1 Yes 2 No specify:	I do	Specify: White
2 hour	eted	15. Decedent's Education (specify only highest grade completed) That Decedent's Education (specify only highest grade completed)	ecedent's Usual Occupation (Give kind of iring most of working life. DO NOT use re		. Kind of Business/Industry
5-0036 led within 72 hou Hygiene, other than "nat the Medical Exa	Completed	12 For	rklift Operator		Construction
21215-0036 vold be filed within 7 Mental Hygiene. marked other than te event, the Medica	Be Co			e (First, Middle, Maide aine Sylvia	
- 4 2 2	To B	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or		
Baltimore, MD 2' permit. Pages I and 2 should Department of Health and MI Important: If item 27 is an injury or other traumatic e			O88 Broadview Dr, A		
Ore, ges lau t of He ther tr		1 Burial 2 Cremation 3 Removal from State cremator	y or other place)		c. Location - City or Town, State
Baltimore, sernit. Pages 1 a Department of He Important: If its injury or other ti		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	more Crematory $ 1/ $ 22. Name and Address of Facility $ J_{ m C} $		Baltimore, MD
Dep Depri		Muselin , blober			Annapolis, MD 21401
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DIV To the Hospital or within 24 hours afte To the Funeral Dir	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.			
H \$ H S	ž	26b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
		(Colineall)	O.C.M.E.	De	ecember 31, 2011
2w	7	30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 V	V. Baltimore Street, Baltimore,	MD 21223	
S		31. Date filed (Month, Day, Year) JAN 0 5 2012 32. Registrar's Signature	hadl		
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DIMINITIFICATION	100	ORME	SINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43555 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31.2011 Rita Cecelia Miller 1:30 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fox Chase Nursing & Rehab Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 158-09-2524 **Director** 1 🗆 M 2 🗓 F 96 June 11, 1915 New Jersey Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director Adelphi 1 Yes 2 X No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2213 Tecumseh Street 20783 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Wildowed 4 Divorced Black Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Computer Analyst Navy Annex Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Elmer Scott Lenora Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 2213 Tecumseh Street, Adelphi, Maryland 20783 Rita Henson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Mt. Olivet Cemetery 101/06/2012 Washington, DC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Womell 11800 New Hampshire Ave., Silver Spring, MD 20904 ace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1 Enter the shock, or heart failure Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Pregnant at time of death Day Year ed by the at 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus Type II 24a. Was an has autopsy page perform certificate I Failure to Thrive 1 ☐ Yes 2 🛣 No 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 은 this 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X.Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of prefix knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) R169951 January 03, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

John Hudson-Odoi.

JAN 05 201

31. Date filed (Month, Day, Year)

CRNP, 15245 Shady Grove Road, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43556 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jean Marie Newcomer 1:15 A. M 2011 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arden Courts of Potomac Montgomery Potomac Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Months 1 M 2 V F Days Hours Min Day 9 ^{Year)}918 93 Director March Maryland 579-10-1475 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Unionville Orange 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8306 Everona Road 22567 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14, Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4x Divorced ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Clerical 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary C. Sponseller Newcomer R. Guaz 19a. Informant's Name/Relationship (Type, Print). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and E. Department of Health and Important: If item 27 is ... iniury or other train 8306 Everona Road, Unionville, VA 22567 Millard F. Ottman, Jr., Date 24 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Georgetown University Washington, D.C. 4 Donation 5 Other (Specify) 2011 Center Medićal 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 le. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Assisted living Other: 4 Nursing Home 5 Residence မ 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DD61382 1-5-2012

Registrar
DHMH 17 Rev 7/2009

State

14816 Physicians Lane

Rockville, MD 20850

Suite 152

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

82. Registrar's Signature

Shama R. Mittal,

JAN 06 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar **Physicia** Medi Examir **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

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Reg. No.

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amir		4a. Facility Name (ii	not institution,	give street and nur	nber)		4b. City, 7	Town, or	Location (of Death		4	c. County	of Death	-	
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Certificate of Death

8/4

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43558 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MILDRED MARIE PALK 2011 1825 Medical 4a. Facility Name (if not institution, give street and nu Examiner 4b. City, Town, or Location of Death 4c. County of Death MedicaL MINSULA SAL 136414 HICOMICO If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 078-07-0373 Director 1 □ M 2**X** F 95 04/21/1916 New York show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar mant be activated. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Somerset Marion Station 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6095 Charles Cannon Road 21838 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Salesperson</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Stenson Flora E. Nostrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Margaret Haase (Niece/PR)</u> 6095 Charles Cannon Road-Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 01/03/2012 Delmar, DE 21. Signatur Sundal Suice Larvee
Robert H. Bradshaw 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Aspiration disease or condition resulting in death) Medical Due to (or as a con **Examiner** Secrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical **the Hospital or Attending Physician:** The law requires that the death certificate be entited to be a first after death. Division of Vital Records, P.O. Box 68760 use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 2 No Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 🔀 No Aspirated Investigation 12/31/11 1800 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Kesturaint - Ruby Tuesdays locomore Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 1/3/12

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State Registrar 30. Name and address of pers

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completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Day Year /Medical ot institution, give street and number) Facility Name (III Examiner 4b. City, Town, or Location of Death 4c. County of Death r If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. Year 1**⊠** M 2□ F Yrs 10ne Director 51 10 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ??...any injury or other traumatic event. the state of the page of the 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No licott owar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4831 21043 by Funeral 0 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Done Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City Hannah Polikov Apt c Manyland 4830 way Joytul 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04, BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 2012 MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SAINT AGNES HOSPITAL - De adress Long BALTIMORE, MARYLAND S. CATON 900 AWENUE 2-12 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each time. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) metur /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 : autopsy performed? certificate 1 ☐ Yes 2 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 🗆 No 3 Suicide ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and tle of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1_ Physician/ December 2011 Elsie D. Queen 10:15AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 881 Annapolis Rd. Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Mayth, Payo Year 1927 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Maryland 219-30-3488 84 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Gambrills 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 881 Annapolis Rd. 21054 USA items death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ō þ 1XX lever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 11th Custodian Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Queen Sr. Dorothy Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Matthews(Daughter) 1702 W. Bancroft Lane Crofton, Md. 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Brooklyn Park, Md. Cedar Hill 1 - 7 - 124 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mmame Received Scillsons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death Physician disease or condition 01 CAFF Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death the detached Unknown g Unknown by significant conditions controlling to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 8 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Desidence 6 ☐ Other (Specify) 27 Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No. 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 12004 completed cause of death (Item egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Constance Irene Rasmussen 51 DM ne cembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Plato Med Char 8. Date of Birth (Month, Day, Year) Nov 11 1923 If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** 1 M 2 V Months Hours England Director 578 40 4614 Nov 11. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Merical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7000 Wood Glen Drive 20637 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than the statement. 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced white Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Frances North James Crome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Rasmussen (Son) 7000 Wood Glen Drive, Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemeterly 1/11/2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition 5 5 6 9 5 5 Approximate Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MENTIA Completed 3 Probably 4 Unknown YOCARDIAL INFARCTION Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? DNEUMMIA 1 Yes 2 No Yes 2 N 25. Was ase referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation

Could not be Accident 24 hours after deat Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ShVINK

DHMH 17 Rev 7/2009

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Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

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	Physicia	an/	1. Decedent's Name (First, Middle, Last)	-				2. D	ate of Deat	h		3. Time of Death	
· Sand	Medi	cal	Richard K. Smith Sr						ecemb	er 28,	2011	5:40 AM™	
	Exami	ner	4a. Facility Name (if not institution, give street and number)	1	4b. City,		thorat			4c. County o		×7	
5	Funeral		25009 Woodfield School Road 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under	1 Year	therst	Hrs. 8. Da	ate of Birth		gomer 9. Birthpla	y ce (State or Foreign	
	Director		Usual Residence of Decedent	79 _{Yrs.}	Months	Days	Hours	Min. pct	nonth, Day,	Ť932	Marty	land	
	arf she	Funeral Director		c. City, Town or Lo							10d	. Inside City Limits	
	he Ma or 28a notif	Dire	MD Montgomery 10e. Street and Number	Gaither	sburg 10f. Zip					10. 000		1 ☐ Yes 2 🛣 No	
	with t	eral	25009 Woodfield School Rd.			882			'	log. Citizen of W	nat Country	7	
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36	after of	by	1 □ Never Married 2 🛣 Married Armed Forces? 1 🛣 Yes 2 □ No 1 If Yes, Give		Yes, speci		, Mexican, P	uerto Rican,	etc.)		, White, etc whit		
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and	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Sherwood Figi Smith					Name (First,		laiden Surname)			
ary	nd Me s marl		19a. Informant's Name/Relationship (Type, Print)	10h Mailin	a Address /	Stroot ar				City or Town, Sta	to 7/2 Co -	7-1	
Σ	nd 2 sl ealth a m 27 is		Shirley Smith - wife	250	009 W	odf	ield S	chool	Rd;	Gaithers	burg,	MD 20882	
Baltimore, Maryland	0		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Ob. Place of Dispos cemetery, crem)	Date	4	20c. Location - C	City or Town	, State	
Balt	permit. Page Department Important: I any injury or		Juni 11	3a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dvine, such as co									
E			shock, of fleat failure. List only one cause on each line.	diac or respi	ratory arres	st,	ln:	proximate terval Between					
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	1			Oı	nset and Death					
-	Examiner		Due to (or as a con										
- E.S.	uted d ansit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):									
	ate be executed physician and the burial-transit	al Ex	that initiated events resulting in death) Last	sequence of):			 -						
760	cate b physi	ledic	d						-				
89	eath certificat attending ph I for use as th	M/ne	IF FEMALE: 23c. If yes, outcome of pre							23d. Date	of delivery		
). Box 687	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1	e of death 5	Other (spe					Mont		y Year	
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a H	hysician: The lav nis certificate has Il director, page 2		25. Was case referred to medical			26. Plac	e of Death (C		☐ Yes 2		Yes 2	No	
<u> </u>	nysici nis cer I direc	10 B	examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient		Othor				ce 6 🗆 Other	Specify)		
Division of Vital Records,	le Hospital or Attending Pr n 24 hours after death. Le Funeral Director: After th oletely filled in by the funeral	Certificate:	27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year 2 Accident Investigation	28b. Time of injury	28c	injury a		28d. De		injury occurred			
isio	er dea ector by the	ertifi	3 Suicide 6 Could not be 28e. Place of Injury - A						cation (Stre	et and Number o	or Rural Rot	ıte Number,	
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	the Hosp nin 24 ho the Fune	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of examinar only one) 1 M Certifying Physician: To the best of my kn condition of the basis of examinar only one) 2 ☐ Medical Examiner: On the basis of examinar only one)	ation and/or investic	ation, in my	noinigo	death occurr	ed at the time	e date and	place and due to	the causels	s) and manner stated. d.	
	© 2 wit		29b. Signature and title of certifier			icense n	umber 14 Z,			d. Date signed (A		· ·	
		}	30. Name and address of person who completed cause of death (I	tem 23a) (Type, Pri				·					
			G. Coleman 1355 Piccord	Dr R	ock vi	lle '	mD						
	State Registra	e r	30. Name and address of person who completed cause of death (I G. Coleman 1355 Piccard 31. Date filed (Month, Day, Year) JAN 2 5 2012 32. Rigistrar's Signary Signa	gnature .	arke	,							

amPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MOET C 2011 10:15 PM SNOWDON ROGER JOHN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WRNMMC BETHESDA 1918
9. Birthplace (State or Foreign Country)
New York 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Year Date of Discourse (Month, Day, **Funeral** Months Days Hours Mir 1 🖫 M 2 🗆 F **Director** Yrs 118-03-6383 93 Feb. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No VA Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3729 Holmes Lane 22302 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Dept of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Snowdon Helen Breed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 19a. Informant's Name/Relationship (Type, Print) Roger J. Snowdon II (Son) 1181 Oak Grove Court Wake Forest, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Metropolitan Crematory 1/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA of Funeral Service 22. Name and Address of Facility METROPOLITAN FUNERAL SERVICE STREET ALEXANDRIA, VIRGINIA 22310 5517 VINE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): a ending physician and f r use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform death? certificate 2 (XNo Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 💢 No ျပ within 24 hours after deau..

To the Funeral Director: After this and annealed filled in by the funeral di 1 Transport 1 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 0101244127 Die 27.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

A WEBER,

LAUREN 31. Date filed (Month, Day, Year)

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32. Registrar's Sgnature

WRNMMC, BETHESDA, MD 20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43564 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pearl Patricia Mason Stokes Medical Dec 2011 6:45 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 530 Temperence Hill Way Harve'de Grace Harford Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours Director 577-62-3856 1 □ M 2 🖺 F 64 2-8-1947 Usual Residence of Deced 28a-f shov 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified TX Yes 2 No MDHarve'de Grace er than "natural", or items 23a or the Medical Examiner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 530 Temperence Hill Way 21078 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.

7 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) System Analyst Pepsi Bottling Group Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence P. Mason Odessa Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Harry M. Stokes/Husband item 2 530 Temperence Hill Way Harve'de Grace MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or otl Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo 4 Donation 5 Other (Specify Beltsville, Maryland Chesapeake Crematory 1-10-2012 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complicate shock, or heart failure. List only one can as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9,579 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Dire to (or said consequence of): Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death isigned by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 24 hours after death.

Funeral Director: After this certificate | 1 Yes 2 No 1 Yes 2 L 25. Was case referred to medical examine ?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital မြ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work?
1 Yes 2 🗆 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			1 ★ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			emetery, crei odlawr				17/2	012	NO	cfol	k ۲	77\	
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The law requires that the death certificate be ten because the has been signed by the attending physici page 2 should be detached for use as the bit		Dy P	Part II. Other significant condition	s contributing to death t	but not res	ulting in the	underlying	cause gi	ven in Part I.		23e. Did	tobacco	use cont	ribute to t	he cause	of death?
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Regi	State stra	٧	31. Date filed (Month, Day, Year) JAN 0 6	2012 32. Registr	ar's Signal	ture	a de	,								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43566 State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Amend #6 perfuneral home 1/11/12 certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 27, Physician/ 201^{Day} Bernice Elizabeth Sescoe 12:53 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Springs Montgomery 8. Date of Birth (Month) 6ay, 19989 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours **Director** 577 54 9931 TX 10 2 X F 72 Dec 27, 2011 Washington DC Usual Residence of Dec 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 1 Tes 2 x No Maryland Oxon Hill Prince George's 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country's 5708 Gallaway Drive 20745 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. ral", or iter Examiner Armed Force Black, White, etc. δ 1 Never Married 2XX Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Completed **Black** Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nursing Assistant Health Care nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Owens Elizabeth 27 is marke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Sescoe (Husband) 5708 Gallaway Drive, Oxon Hill, MD 20745 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I Important: If its any injury or or 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1/10/2011 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service License Ferry Road, Clinton, MD 20735 N101549 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Respiratory Failure disease or condition Medical resulting in death) **Examiner** Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transi Accute Chronic Renal Disease and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ó in the past 12 months? Month Day Year ned by the at detached for Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 24 hours after death. Funeral Director: A Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Fo the within To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D55475 Dec 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gebremedhin Yohannes, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 43567 State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Charles Hamilton Seek JR 29,201 I 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Run Road Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Days Months 06/104/11926 579-30-7180 Washington DC 85 Director Usual Residence of Decedent 28a-f shov 10a. State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Anne Arundel Annapolis 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 307 Carriage Run Road 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 【文 No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry المالية filed with. خا Hygiene. خال ته than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Collection Supervisor Washington Gas Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of ည Charles Hamilton Seek Lillie Engle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Evelyn Seek Spouse 307 Carriage Run Road Annapolis, MD 21403 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crematory 12/31/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis, MD 21401 Vati 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ cardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner disease ovonav Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has Hospital or Attending Physician: The 1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🗹 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

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To the Funeral D

completed filled i Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 44 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis arkowski Trederick

State Registrar 31. Date filed (Month,

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dammarco 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. **Director** 077-20-3585 1 🗆 M 2 🕱 F 84 New York 8/10/1927 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 X No ems 23a or r must be r 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2595 Golfer's Ridge Road USA 21401 items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ian "natural", or itei Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " rent, the Med College (1-4 or 5+) Elementary/Secondary (0-12) 2 should be filed with th and Mental Hygien 7 is marked other th Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anthony Regina other traumatic Carmela 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $132~{
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m Owings}~{
m Mil1},~{
m MD}~21117$ Department of Health at Important: If item 27 is any injury or Att Robert Sammarco - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2012 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Muzeli 1.W Gloucester St. Annapolis MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iad Ph sician/ conces disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Pregnant at time of death 9 Unknown g Unknown n signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autops, performed 2 hours after death. neral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2. No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MI

Registrar

DHMH 17 Rev 06-2011

State

210 Annanil 13 MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 05 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 43569 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nikolaos A. Stavrou December 2011 3:32 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 370-40-7921 Director 1 🖾 M 2 🗆 F 76 05/05/1935 Greece Usual Residence of Decedent 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s' must be notified MD Bethesda Montgomery 1 X Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 5405 Glenwood Road ral", or items ? Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 X Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: Year or Dates. White Unknown It of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical! Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Professor at Howard University (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aristoula Laiou Anastasios Stavrou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5405 Glenwood Road Bethesda, MD 20817 Katarina Stavrou / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 1/02/2012 Rockville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition Medical resulting in death) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Due to for as a consequence of Examir that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No detached the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 XYes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After this stelly filled in by the funeral di 27. Manner of Death 28b. Time of Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔼 Natural (Month, Day, Year) 5 Pending injury death. Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours Medical

State Registrar Muri a Duychak

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check

only one)

within 2 To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

12/29/2011

29c. License number

D0041311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ™112/31/2011 07:55 AM FILOMENA VILLARICO SANTIAGO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5607 Temple Hills Road Temple Hills Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕇 F Davs Hours (Month, Day, March 8 77 250-82-1382 **Director** 1934 **Philippines** Usual Residence of Decedent show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified a or 28a-f 1 X Yes 2 No Temple Hills MD Prince Georges 10g. Citizen of What Country? Examiner must be 23a Funeral 5607 Temple Hills Rd. 2074A AZU Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: Asian 3 🗌 Widowed 4 🗆 Divorced Year or Dates. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 75 Teacher other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Telesforo Villarico Leonora Andava 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5607 Temple Hills Rd,Temple Hills,MD 20748 Roberto Santiago / husband permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 01/05/2012 Clinton MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Strickland Funeral Services <u> 6500 Allentown Rd., Camp Springs, MD 20748</u> 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 years Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaonying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death
Unknown Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗡 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗆 No 2 **X** No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: [교 1 Yes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, death. Director /

State Registrar

29a. Certifier

(Check

Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

890] Wisconsin Ave., Bethesda, MD 20899 <u>Cathy Franklin</u> 32. Registrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

2011

1410

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

160010 cm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ÎÎ 16:45 P M William Charles Tilling December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 577-40-5204 Director 1 **XX**M 2 □ F Usual Residence of Decedent 83 August 20, 1928 New York show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2XX No Maryland Prince Georges Temple Hills 10e. Street and Number ms 23a or ò 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 6912 Westchester Dr. U.S.A Late 15-0036

Leannit. Page 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic event." 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. 1XXNever Married 2 Married 1 XX Yes 2 If Yes, Give Year or Dates þ 1 Yes 2 No Specify White Completed 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Horticulture Nurseryman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Andrew C. Tilling Florence C. Whor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence T. Dimmick (Sister) 102 Crossing Point Ct. Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Signature of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying stock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetland Peath Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or Examir Cause (Disease or injury that initiated events and Due to (or resulting in death) Last attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death the : 9 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. Certificate: 28c. Injury at 28d. Describe how injury occurred 10 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on re and title 29b. Signaty

State Registrar LAXMI

31. Date filed (Month, Day, Year)

 \triangleright

7760 OLD BRANCH PUENUE,

101C, CLINTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

BERWA. MO

3 2012

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			for State Registrar		<i>y</i>			e of D			Reg. No	20	11 43572
	Dhuniai	on/	1. Decedent's Name (First, Middle, Las	st)						2. Date of I		av ov y	3. Time of Death
	Physici Medi		Louis		1	<i>N</i> .			mpsonS			24	2011 3:21 pm
	Exami	ner	4a. Facility Name (if not institution, give Civista Medica	al Cente	<u>r</u>			Lal	ocation of Deat			c. County of Cha	rles
	Funeral Director		5. Social Security Number 217-36-9523 Usual Residence of Decedent	iex 7. Age	72	ast birthday) Yrs.	If Under Months	Days	Hours Min.	8. Date of E (Month, I 5 – 1 9	Day, Year) 0 - 39	M	B. Birthplace (State or Foreign Country) Laryland
2	land show	ţō	10a. State 10b. County	•	10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
NS M18853	thin 72 hours after death with the Maryland nne. than "natural", or items 23a or 28a-1 shov he Medical Examiner must be notified at	Funeral Director	Maryland Charle 10e. Street and Number	s	Br	yantow	7 n 10f. Zip	Code			10g. C	itizen of Wh	1 XYes 2 No nat Country?
∞	s 23a ust b	era	6360 Sunbrook	Place				206	17 _			USA	
5	death item ner m		11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. W	/as Deced Yes, spec	lent of His lify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No o Rican, etc.)	0~		American Indian, White, etc.
36	after al", or xami	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes	2 🗙 No	Specify:			Specify:	Black
\sim	72 hours n "natura Aedical E	lete	15. Decedent's E	ducation		16a. Deced	ent's Usua	al Occupat	tion	4.5-	16b. ł	Kind of Busi	ness/Industry
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	2 shoi th and 27 is n		19a. Informant's Name/Relationship (7			· ·			nd Number or Ru				
2	f Heal f Heal item		Edith Thompson 20a. Method of Disposition		20b. F	lace of Dispos	ition (Nan	ne of		Date			20617 ty or Town, State
	Page nent o		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special			emetery, crem • Marvs	,		Ch 12-	31–11	Brya	antow	n Md
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2"	9 0 E 8 9	L	23a. Part 1. Enter the disease, or com	THAN					eral H			uasco	
F	√Physician/ Medical ∕Éxaminer		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line Due to (or as a	Car	Dial			foreti		arest,		Approximate Interval Between Onset and Death
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		1	resulting in death) Last	Due to (or as a	ı conseqı	uence of):							
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Box	ne death c the atten	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Feta	al death 3 🗌	Ectopic p Other (sp				-	23d. Date of Month	*
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her P	quires en sig ould b	ted		W. C.						1 🗆	Yes 2	∠ No 3	☐ Probably 4 ☐ Unknown
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of of	ding Phys h. After this funeral di	e: To	27. Manner of Death	28a. Date of injur (Month, Day	ν	28b. Time of		8c. Injury		lome 5 Re 28d. Describe			<u>Бресіту)</u>
	uttending death. ctor: Afte y the fur	ficat	1 Natural 5 Pending 2 Accident Investigation	1	rear)	injury	М	work?	es 2 🗆 No				
# Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	I Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . <i>(Specify</i>	me, farm, stre	et, factory	, office			(Street ar bwn, State		r Rural Route Number,
	Hospital 24 hours Funeral etely filled	Medical ((Check 2 Medical Exami	sician: To the best of a iner: On the basis of ex	amination	and/or investig	gation, in r	ny opinion	, death occurred	at the time, date	e and place	e, and due to	the cause(s) and manner stated
	To the I within 2 To the I comple	ž	only one) 3 Certifying Nurs	se Plactitioner: To the	best of n	ny knowledge,		urred at the License r		place, and due to			ner as stated. fonth, Day, Year)
	FŠFÖ		1 Pames	Harry					5291	9	12	1281	71
	21-3		30. Name and address of person who o	1	eath (Item	23a) (Type, Pr	int)						1 40 - 1111
	pu,		James Harring	MD 102	2 CA	entenn	ial:	Stre	et Su	ite 10:	24	a Pla	ta, MD 20646
	Sta Registr		31. Date filed (Month, Day, Year) 2012	72. Registra	r's Signat	ture							

11-09853 Chappell Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Chappell Wilsor		Stat 1- For State Registrar	e of Marylan		artment of <i>rtificate</i> of		d Mental		Reg. No. 2 (1 4357
Physici	an/	1. Decedent's Name (First, Middle,L						2. Date of De Month	r 3	3. Time of Death 0945 hrs	
Medical Exami	ner	Chappell Wils 4a. Facility Name (if not institution,		er)		4b. City, Town, or	Location of De		er 31, 2011	of Death	0945 HIS
		3805 Walters Lane		,		Forestville	eorge's	S			
Funeral Director			Sex 7.	Age (In yrs. la	ast birthday) Yrs	If Under 1 Year Months Day			irth(MM/DD/YYYY 7/1959	Foreign	place (State or ntry) DC
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locat	ion					10d. Inside City Limits
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e Maryland or 28a-f show fied at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh		•
3a or 3		3805 Walters	Lane			20747	7		United	Sta	tes
5 72 hours after death with the Maryland 1" "astural", or items 23a or 28a-f sho 2al Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marri	1 Yes		If Y	s Decedent of His es, specify Cubar	n, Mexican, Pue		White		an Indian, Black,
rs after ural", miner	ģ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:	completed)		Yes 2 No		of work done	Specify: 16b. Kind of Bus		
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OO36. within 7: giene. her than	d	12			Plum				Constr		ion
	Be Co	17. Father's Name (First, Middle, La Samuel Wilson		·				me (First, Middle, ney Dio	Maiden Surname)		
21215. 21215. Suld be filed Mental Hy marked of	ု	19a. Informant's Name/Relationship	(Type, Print)				et and Number of	or Rural Route Nu	mber, City or Town		
MD d 2 sho lith and n 27 is		Courtney Padge	tt (moth						ell, SC		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and IN Important: If item 27 is in injury or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from		Place of Dispos crematory or oth	ition (Name of ce ner place)		Date	20c. Location -		
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		4 Donation 5 Other Spec		Gle		Cemete	ery 0	1/07/20	12 Wash on Funer	iing	ton,DC
Bal permi Depar injur		Wanda C. Baco							n Funer .ngton,		
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on	mplications that caus	sed the death.							Approximate Interval Between Onset and
Medica. Examiner		Immediate Cause (Final disease	_{a.} Sharp Force							- 5	Death
		or condition resulting in death)	Due to (or as a co	insequence o	f):						
	je i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	f):						
h	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of	f):		1				
to, e be executed ysician and	a E		d								
O, e be ex sician burial	edical	UNPENDED	AMENDED						Tool 5		
6876 certificat nding ph	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno		n t at time of de	2 Fe	tal death 3	Ectopic preg	gnancy	23d. Date of Month	delivery Da	y Year
n of Vital Records, P.O. Box ding Physician: The law requires that the death After this certificate has been signed by the atte funeral director, page 2 should be detached for u.	Phy	Part II. Other significant condition	19 Olikiowi		esulting in the u	inderlying cause	given in Part I.	23e, Did	tobacco use contri	bute to th	ne cause of death?
, P.O. rres that the signed by be detach	ē				Ü		•	1 🗌 Ye	es 2 🗹 No 3	Proba	bly 4 Unknown
Division of Vital Records, I salor Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was			opsy findings available mpletion of cause of
Reco	E O		_					perf	ormed? d	eath? ✓ Yes	_
tal Rec ician: The l certificate l rector, page	Bec	25. Was case referred to medical examiner?	11			26.Place	of Death (Che	ck only one)	<u> </u>		
Physic ral dire	P	1 ✓ Yes 2 No 27. Manner of Death	28a Date of	atient 2	ER/Outpatient 28b. Time of I		Other Nur	sing Home 5	Residence 6 v		Scene
on of anding Ph	ğ	1 Natural 5 Pending	FOUND: D	ay,Year)	FOUND:	· · I _ ·	Yes 2 ✓ No		bbed and cut		
ViSic or Atte fler de: Directo	Certification:	2 Accident Investig 3 Suicide 6 Could n	28e Place o		0930 hrs ome, farm, stree	et, factory, office b	ouilding, etc.			r or Rura	al Route Number, City
Diversible	Cert	4 V Homicide determin		Single Fam	nily Home			or Town, 3805 Walter	s Lane, Forestvil	le, MD	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	Medical	29a. Certifier 1 Certifying Physical Control 2 Medical Examination	lician: To the best oner:On the basis of each manner state	examination a	ge, death occur ind/or investigat	red at the time, dation, in my opinion	ate and place, a n, death occurre	and due to the cau d at the time, date	use(s) and manner e and place, and di	as stated ue to the	d. cause(s)
3	Me	29b Gignature and title of certifier	1/01/	1/1 2/	20	29c. Licens			29d. Date signe		h, Day, Year)
		Cielo Nato	e-Vale	1	الحال	O.C.	M.E.		January 1,	2012	
		30. Name and address of person whe Victor Weedin MD JD	o completed cause of Assistant Medic			/. Baltimore S	Street, Baltin	nore, MD 212	223		
St Regis	ate trar	31. Date filed (Manth, Day, Gar)		strar's Signar							
	_		7	- V							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day Physician/ 10:15 am Gill Samue1 Washington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medic Sex 14 M 2 D F 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Aug. 31, 1955 Country) 215-62-9340 56 MD **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MDCalvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11487 H.G. Trueman Road 20657 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Mail Carrier Postal Service Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Washington Buena V. Bishop permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic vines. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney Washington/ P.O. Box 975 California, MD 20619 son timore/ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) John UMC Cem. 1/7/2012 Lusby, MD 21. Signature of Funeral Service 22. Name and Address of Facility Sewell Funeral Home Joshin 451 Dares Beach Rd., Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Dancrea hc disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably A Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No မ 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier well 566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW) Michel La Plata 20646 MO Garrett 32. Registra s Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per phys 127 127 12 years.

State of Maryland / Department of Health and Mental Hygiene 43575 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jacqueline Loretta Wilson Physician/ Month Day 2:30 P Jacqueline Dec 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Pineview Nursing Home Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Days Hours Min. (Month, Day, Year 218 40 3023 Jan 31 Director 1041 Cumberland, MD Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Prince George's Temple Hills 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3205 Carlton Ave United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bar Manager American Legion Post 248 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 6 Harrison Thrasher Betty Mayle and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trav Kathleen Kight (Sister) 330 Dorn Ave, Cumberland MD 21502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1/9/2012 Cheltenham. MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licens Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Respiratory Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine and -transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): -purialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, or Attending Physician; The law requires 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical director. 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Doubth 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 💓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) Ba-10 Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, 32. Registrar's Signature JAN 0 3 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20a&20c Certificate of Death Registrar Amend#20bperfuneralhome1/4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Adolf M. Werbowetzki Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata ivista 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1 ★M 2 □ F Months Days Hours Min. Country) 334 28 2504 77 Director July 6, 1934 Chicago. T1 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Funeral Director items 23a or 28a-f s er must be notified 1 Yes 2 XXNo Maryland Prince George's Clinton 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number United States 6009 Runnymeade Ave 20735 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or iter Vas Decedent Ever in U.S.
Armed Forces?

1 V Yes 2 No Korean
If As, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by filed within 72 hours after 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NOAA/NASA Sr. Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental Josephine Dobrowolske ပ Michael Werbowetzki Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilia Werbowetzki (Wife) 6009 Runnymeade Ave, Clinton, MD 20735 Baltimore, Important; If item any injury or other 20a. Method of Disposition

1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 28, 2011 cemetery, crematory or other place)
Lee Crematory
Aryland Veterans Cemet Department of Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Cometery Cheltenham MD permit. 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses ennet Ferry Road, Clinton, MD 20735 MO1549 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed 1 ☐ Yes prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Munpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one 29c. License number 29d. Date signed (Month, Day, 29b. Signature and title of ce Post Office Rd enna 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 2012 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink 5 Ensure Alb Capies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:20 P^{M} December <u>Jane Watson</u> Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Brandywine 18012 Aquasco Road Date c. (Month, Da, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 X F Months Hours Min 86 Director 218-16-2064 Maryland Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location death with the Maryland at Director notified 1 Yes 2 No Maryland Prince Georges Brandywine ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 18012 Aquasco Road 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? Ves 2 1 No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural". Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Prince Georges Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claude Gibbons McKee Edna Greenawalt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn McKee/ Niece 8121 Mandan Terrace, Greenbelt, MD. 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Trinity Mem. Gardens | Jan. 4, 2010 Waldorf, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and D, ath ardis vasalar Nislass Immediate Cause (Final The voscleroti Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Lyes _ _ 9 Unknown should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performed 2 No 1 Tyes Yes 2 of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0045365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SidaRous Livingson Road suite#101 Ft. Wash Mis 20144 Michael 11701 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day 31 Physician/ Louise Rossiter Wooddy 2011 10:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛱 F Hours Min. 09/02/192 Country) Pennsylvania 90 **Director** 166-14-6679 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 616 Wayward Drive 21401 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married β 1 Yes Baltimore, Maryland 21215-0036 72 hours after Specify:White 1 ☐ Yes 2 X No Specify: n and Mental Hygiene. Completed 3 Widowed 4 X Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Frank Rossiter Elizabeth Haupt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur R. Wooddy/Son 616 Wayward Drive, Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Metropolitan Crematory 01/17/2012 Alexandria, VA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Advent Funeral Services 42 Hudson St., Ste. 110, Annapolis, MD 23a. Part 1. Enter the contact of december of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart fails that cause on each line. Approximate Interval Between Immediate Cau e (Final Onset and Death Physician/ Septic 5 disease or condition Medical resulting in death) Examiner Sequentially list conditions, it my leading to in reclaim cause. Enter Underlying Examiner sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 month 1 ☐ Yes 2 ☑ No Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes this (1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Nume Frantianer To the best of my knowledge, decth occurred at the time, data at diplace, and due to the 29b. Signature and title of certifie Vano 5829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD ouns AnneArun

DHMH 17 Rev 7/2009

Registrar

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Medica Examine		4a. Facility Name (if						4b. City, Town, or Location of Death					4c. County of Death				
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signature of Fu			_		1			ss of Facility St							
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 Suicide 4 Homicide	6 Coul	d not be mined	28e. Place o	of Injury - At g, etc. (Spe	home, farm, s	street, factor	y, office		28f. Location City or To			r or Rur	al Route No	ımber,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER A^{M} ZALIAN 6:54 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 2, 1978 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 ₺ M 2 □ F Days Min. Hours Country)
Maryland **Director** 586-39-7173 33 Usual Residence of Decedent or 28a-f shov notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe "natural", or items 23a edical Examiner must b Funeral 9056 Brookhaven Terrace 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Translation Svcs. Interpreter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke Hleiza Za Ni Dong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hlei Za/ Father 9056 Brookhaven Terrace, Frederick,MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page Department o Important: If any injury or ö X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/7/2012 Olivet Cemetery Frederick, Maryland. Mt. 2. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Signature of mineral Service Linens Homes Pike, Prederick, Maryland 21702 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that Approximate Interval Between shock, or heart failure. List only one cause of Immediate Cause (Final Onset and Death Physician/ FAIL disease or condition resulting in death) LEDATIC Medical Due to for as a consequence of Examiner Sequentially list conditions, if any leading trimm, for cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death signed by the a Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? After this certificate I 2 X No 2 X No ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Yes 2 💢 No Other; 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cert 29d. Date signed (Month. Day, Year) 1 Livet 12/31 MDD70559 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Donald R. Bennett, MD 400 West 7th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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		For State	State of I	Maryland / Dep			Mental Hy	giene	011 [050]
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21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho,; the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🗶 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 [If Yes, Give Year or Dates.	1957-60	1 ☐ Yes 2 😿 No	Specify:			Caucasian
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Malth au 27 is rrtrau		Keith Zonts, Son		100	Stellar I				
of Heal		20a. Method of Disposition		20b. Place of Disp			Date		- City or Town, State
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Baltimore, I permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lic	ensee MC	2 2	2. Name and Addres	s of Facility	imple Tr	ibute	
n 507 8 6		MALKO	WE.						Maryland 20852
		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	ly one cause on each li	ine.			ac or respiratory arr	est,	Approximate Interval Between Onset and Death
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60 ate be executed bhysician and the burial received	<u>=</u>	resulting in death) Last	Due to (or a	s a consequence of):		5 , /			
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriares.	edical		d						
Hecords, P.O. box 687 The law requires that the death certific ate has been signed by the attending I page 2 should be detached for use as	Ž	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				00.1.5	
Box 68 death certificate attending ed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 🔲 Live Birth	n 2 🗌 Fetal death 3 🏻	Ctopic pregnanc	у			ate of delivery onth Day Year
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DIVISION OT tall or Attending Pt is after death. In Director: After the din by the funeral	Certificate:	3 Suicide 6 Could no	t be 28e. Place of Ir	njury - At home, farm, st					er or Rural Route Number,
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DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P	hysician: To the best of	of my knowledge, death	occurred at the time	, date and place	, and due to the ca	use(s) and man	ner as stated. le to the cause(s) and manner stated.
thin 2 the l	×	only one) 3 Certifying N	urse Practitioner: To	the best of my knowledge	, death occurred at th	ne time, date and	place, and due to the	e cause(s) and r	manner as stated.
		29b. Signature and title of certifier	· ' MD		29c. License			29d. Date signe	d (Month, Day, Year)
		30. Name and address of person wh		death (Item 23a) (Time		<i>) 0</i>		-/11/	
		1.		Locks Road		00. Roc	kville N	(arvl on	a 20854
Sta	te	31. Date filed (Month, Day, Year)	2. Regist	trar's Signature	A A	.ou, noc	WATTIE !	rar A Tall	4 20074
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ΪΌ, 2ďT1 9:00 PM M December Norman E. Aldridge Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Carroll WEstminster 751 Muller Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 220-18-1382 87 1 🔀 M 2 🗆 F **Director** Feb 6, 1924 Usual Residence of Decedent Maryland 28a-f shov 10b. County items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Carrol1 MD Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21157 USA 751 Muller Rd. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 If Yes, Give Year or Dates. 1943 Black, White, etc. ò þ 1 Never Married 2 Married 2 No Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 Divorced 1946 Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 home improvement carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Mildred Elizabeth Grimes Ensor Hanson Aldridge other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 751 Muller Rd; Westminster, MD 21157 Cassie Aldridge - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) of Funeral Servi 22. Name and Address of Facility State Anatomy Board tor 21201 655 W. Baltimore St; Baltimore, MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Ph_sician/ e disease or condition menos Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year signed by the at I be detached for Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 1 No 2 No Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 A Marsing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene ne. 125,27,28a-1 per me. 127,2012dhb Registrar Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Stanley 6:54PM Ashley 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore VA Medical Center Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F (Month, Day, Year) 214-56-6734 59 Months Days Hours Min. Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 401 E. 25th 9-D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs Laborer college Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Wallace Elijah Ashley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Ashley-Mother 1634 Normal Ave. Baltimor, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cemt. 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 10/13/201 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 1101 E. North Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CERTIFICATION APPROVED BY METERICAL EXAMINER Weeks Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregna
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HIV Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Hep C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No Small Bowel obstruction 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After that in by the funeral Certificate: 27. Manner of Death 28a. Date of injury **Found**^{h, Day, Year)} 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be **Unknown** M 1 Yes 2 X No Unknown Accident 10/2011 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Unknown Unknown within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10.11.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Wang

MD

3/2. Registrar's Signature

10 N. Greene St. Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per INF G925 3/01/2012 JH State of Maryland / Department of Health and Mental Hygiene 43584 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEcember 10, 2011 William S. Brower Jr 3:55 AM M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11450 Asbury Circle #404 Calvert Solomons 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 95 579-16-5886 Director 1 XM 2 □ F Sept 2, 1916 Usual Residence of Deced Virginia 28a-f show 10a State 10b. County items 23a or 28a-f sho her must be notified at 10c. City. Town or Location 10d Inside City Limits 1 Yes 2X No MD Calvert Solomons 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20688 11450 Asbury Circle #404 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Annarried þ Specify: White 1 ☐ Yes 2 X No Specify "natural", 1971 3XXWidowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the 10 0 military US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Spencer Brower Sr. Stella Huffman Hammack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Hammack - cousin 3226 Brookings Ct; Fairfax, Virginia 22031 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Romald States 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCE UNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed PARKINSON DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) D0067788 1.9.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI, 14090 H.G. TRUEMAN RD ., SOLOMONS, MD 20688 31. Date filed (Month, Day, Year) FEB 0 1 2012

DHMH 17 Rev 06-2011

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

32. Registrar's Signature

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	Funeral Director		5. Social Security Number 214–18–2220	6. Sex 1 ☐ M 2 🔀 F		yrs. last birthda 86 Yrs	′′ Г	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth av, Year) 24)	9. Birth Mar	place (State or Fore yland	ign	
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>چ</u>	1 ☐ Never Married 2 ☑ Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Blac 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Specify: Specify:												American Indian, White, etc.		
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Baltimore, Maryland	permit. Depart Import any inj once.		21. Signature of Funeral Service Li	ensee 2	4	/		Name and Addres									
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. Box 68760	he death certificate be y the attending physici ched for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Birth 2 🗆 nant at time	Fetal death		Ectopic pregnancy Other (specify)	у				23d. Date Mont		ery Day Year		
P.O.	law requires that the de- nas been signed by the a s 2 should be detached	by P	Part II. Other significant condition	s contributing to d	eath but no	ot resulting in th	ne und	derlying cause give	en in Part	l.	23e. Did 1	tobacco	use contrib	ute to t	he cause of death?		
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Division	in the Hospital or Attending Phys within 24 Hospital or after death. To the Tuneral Director After this completed filled in by the funeral dir	al Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	1 28e. Place	of Injury -	nome, arm,	stree	t, factory, office		2		Street a	nd Number	or Rura	Route Number,		
:	ne Hosp in 24 hou he Funer pleted fil	Medical	(Check 2 L Medical Ex	Physician: To the ba aminer: On the bas Nurse Practioner:	s of examir	nation and/or in	vestig	ation, in my opinior	n, death o	ccurred at	the time, date a	and plac	e, and due to	o the ca	use(s) and manner si	tated.	
	with com		29b. Signature and title of certifier	Lyde	25			29c. License	number	700		29d. D.	ate signed (Month,	Day, Year)		
	4)		30. Name and address of person wi	no completed caus	e of death	(Item 23a) (Typ	e, Prir	nt)	2	((,,,,		ا م	 "				
E	Stat		31. Date filed (Month, Day, Year)	2012 32/Re	egistrar's S	ignature	6-	V. 1	1 /		i						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Location of Death 4c. County of Death and US (SWN how Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) unk 8. Date of Birth Months Days Hours Min (Month, Day, 6721 **Director** 1 🗆 M 2 🔽 03 08 2 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits MD Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code Citizen of What Country? 10g. 501 Dolphine St. #615 21217 USA unk 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname)unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Future Care - Sandtown 1000 N. Gilmore St; Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 □ Donation 5 N Other (Specify) in state Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the n Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the at d be detached for Pregnant at time of death Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 100 Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

FEB

72. Registrar's Signature

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #2 PER PHY \$#19A PER ANA BD \$6923 1/30/2012 JH

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 3. Time of Death Physician/ Month Kenneth Taylor Eldridge 2010 2:40 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Worcester 3 Fort Sumter North Berlin 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day,) Months Days Hours Min. Country) Massachusetts Director 0ct 012-20-3780 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 X No Worcester Berlin 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3 Fort Sumter North 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No 1943If Yes, Give
Year or Dates. 1945 Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay Elementary/Seconday (0-12) College (1-4 or 5+) school principal education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Reubin Eldridge Ruth Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Cook -3 Fort Sumter North; Berlin, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate o beart failure. List only one caus Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 7 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) Manner of Seath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accident the . Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 29b. Signature MD2/802 State JAN 30 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Pleas	e Type or Pr State of N		/ Dep	artment of H	lealth and I	-		gible.	10500
Physicia	n/	Registrar 1. Decedent's Name	1		ricke		rtificate of L	Dearn	2. Date of Dea Month	th Day	Year	3. Time of Death
Medic Examin	er	Cheste	not institution, g	ve street and number,	nor		Ches	Location of Death	on	4c. Coun	ty of Death	
Funeral Director		5. Social Security No. 206-20-4 Usual Residence of	361	Sex 1 ▼ M 2 □ F	Age (In yrs. last 84	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day June 18	Year) 1927	Count	olace (State or Foreign try) nnsylvania
Maryland 28a-f sho notified at	Director	10a. State	10b. County Kei	nt	10c. City, 7	Town or Lo	11		·			0d. Inside City Limits 1 Yes 2 No
ems 23a or r must be	Funeral Director	10e. Street and Nur 5696 M 11. Marital Status	ain St.	12. Was Deceden		13.	10f. Zip Code 21661 Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	10g. Citizen of USA		
ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Marri	4 Divorced	If Yes, Give Year or Dates.	□ № 1944 1947	7	If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	Specify:	Rican, etc.)	Specii		te
vithin 72 ho jiene. er than "nai the Medica	Completed	(Spe Elementary/Seco 12		Education grade completed) College (1-4 o		(Give life. D	dent's Usual Occup kind of work done o O NOT use retired) 1f employ	during most of worl	king	16b. Kind of		industry
ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (I	First, Middle, Las Mienel					18. Mother's Nan	ne (First, Middle, I ne Emma		ne)	
and 2 shou Health and em 27 is m ther traum:		19a. Informant's Na Carole 20a. Method of Disp	Fricke		20h Blo	56	ng Address (Street a		Hall, MD			
t. Pa tmer tant jury		1 🗆 Burial 2	☐ Cremation 3		te cen	netery, crei	matory or other place		ate Anat		_	
permir Depar Impor any in once.		Ro 23a. Part 1. Enter t	nald S	mplications that caus	ector		655 W. I	Baltimore	St; Bal	Ltimore		Approximate
Physician/ Medical Examiner		Immediate Cause (disease or conditio resulting in death)	Final	d	S a consequer		i Stevos	15			;	Interval Between Onset and Death
4.	Examiner	Sequentially list co- if any, leading to im- cause. Enter Under Cause (Disease or	nmediate rtving	b. Due to (or a	s a consequer	nce of):						
eath certificate be executed attending physician and for use as the burial-transit	ā	that initiated events resulting in death) I	s	cDue to (or a	s a consequer	nce of):					\downarrow	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No		n 2 ∐ Fetalo tat time of dea	death 3 L	☐ Ectopic pregnanc☐ Other (specify)	sy			Date of delive	ery Day Year
v requires that the de sbeen signed by the should be detached	ed by P	Part II. Other signif	icant conditions	Contributing to death Africa (Fig. 1850) Siow Dy	but not result	ing in the c	underlying cause giv	ven in Part I.	.	es 2 No		ne cause of death?
The law rec ate has bee page 2 sho	Complet	Pulmonun	Hyperc	sion, Dy	s)ipile	niu			24a. Was a autop perfor	sy	prior to co death?	osy findings available mpletion of cause of
sician: certific irector,	Be	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:			Othe	ace of Death (Chec				
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	Accident Control Contr	Investigat 6 Could no determine	ion t be 28e. Place of I				Yes 2 No	28f. Location (S City or Tow		ber or Rural	Route Number,
ne Hospital n 24 hours ne Funeral pleted filled	Medical		Medical Exa	hysician: To the best miner: On the basis o urse Practioner: To the	f examination a	ind/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	nd place, and c	due to the cal	use(s) and manner stated.
To the within comment of the comment		29b. Signature and	1/1	M			29 c. License			29d. Date sign	ned (Month, I /2012	Day, Year)
		30. Name and addre	ess of person wh Speer	completed cause of	est Ao	3a) (Type, I	0006 MO 2(6)	20		•		
Stat	е	31. Date filed (Monti	R 0 1 20		trar's Sign	par	Ke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #12 PER INF G924 2/10/12 TRT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 14, Thomas Joseph Hardy December 2011 6:04 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 114 Perrys Road Grasonville Queen Annes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. Hours Director 577-42-6763 80 1X M 2 □ F Sept 6, 1931 Usual Residence of Decedent Indiana 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Queen Annes Grasonville 1 ☐ Yes 2X No ems 23a or r must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 Perrys Rd. 21638 USA death items 12. Was Decedent Ever in U.S. Armed Forces?

1 N Yes Armed Forces?
1 Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: white 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 special agent US government Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f. Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev ည John bruce Hardy Barbara Ellen Kain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Hardy - wife 114 Perrys Rd; Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🗀 Cremation__3 🗀 Removal from State 4 X Donation 5 Dother (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Ronald S Wa 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ chronic disease or condition <u> 5 vears</u> Medical resulting in death) Due to (or as a consequence of) Examiner cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ o in the past 12 months? Month Day Year the a Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ neart disease Completed 1 XYes 2 No 3 Probably 4 Unknown been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of within 24 hours after death. **To the Funeral Director:** After of completely filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOWIE Anarew Dobin 75 Hanson C+ #200 31. Date filed (Month, Day, Year) FEB 0 1 2012 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g923,01/27/2012 db Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death HEI Physician/ 1120 M HEL 20 4 Medical 4a. Facility Name (if not institution, give street and number)
318 West Road Town, or Loca Essex **Examiner** or Location of Death County of Death Baltimore If Under 1 Year Months Days 5. Social Security Number 220-14-7894 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) MArch19, 1927 Hours Country 84 Yrs. **Director** 1 M 2 XF MD 28a-f shov 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 318 West Road 21221 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc or 1 Never Married 2 Married 2X No ð 1 Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White "natural", 3 XWidowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Murray Inc. Elementary/Secondary (0-12) College (1-4 or 5+) Inspector 7th other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F ris marked o 2 Charles E. Cameron Jennie Cottrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau James W. Heil /son 2341 Barrison Point Road Balto. MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State Gardens of Faith 12/22/11 Rossville MD 4 Donation 6 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility 300 MAce Ave. Balto. MD 4 Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami should be detached for use as the burial-transit that initiated events resulting in death) Last APPROVED BY MER Due to (or as a consequence of) the attending physiciar Physician/Medical CERTIFICATION Hospital or Attending Physician: The law requires that the death certificate be 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 Yes 2 No Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one)

examiner? 1 X Yes Hospital: Other: 욘 1 Inpatient 2 I ER/Outpatient 3 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

within 24 hours after death.

To the Funeral Director: After this completely filled in by

Division of Vital Records, P.

State Registrar

29b. Signature and title of certifier

ed cause of death (Item 23a) (T

11-09445 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sarah Elizabeth Hennig State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month SARAH **Medical Examiner** 2129 hrs December 15, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 205 West Pulaski Highway Room #38 Cecil 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Director 37 Months Hours Min 222-60-190 Country) DEL Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ELKTON 1 Yes 2 No other than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNKNOWN U.S Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes WHITE 4 Divorced If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 DISABLED 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) CLARENC SEATRICE 19b. Mailing Address (\$treet and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER ELKTON 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department of Important: I ATLANTIC CREMATURY Donation 5 Other Specify permit. gnature of Funeral rvice Licensee 22. Name and Address of Facil HOME 2829 HUDSON ST. 2122 FUNERAL 23a. Part I. Enter the difference or complications that cause the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Combined drug(Fluoxetine and Hydroxyzine)Intoxication Immediate Cause (Final disease غxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Sa AMENDED 23a,27,28a-f,per me,g924 2-15-12 sm *UNPENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending subject ingested prescription 1 Yes 2 X No fd 12-15-11 fd 9:20 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 205 West Pulaski Howy 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide 6 Could not be (Specify) Found: Residence Homicide Elkton,Md. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

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State Registra

29b. Signature and title of certifie

Laron Locke MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 16, 2011

W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 43593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 234 2011 9:10 Ам Iris Dorothy Kairis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dunda1k 7407 Edsworth Rd. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) 75 212-34-8576 1 □ M 2 F Director Usual Residence of Decede March 21, 1936 Maryland or 28a-f show with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore Dunda1k 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Edsworth Rd. 21222 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Paul Frederick Stiegmann Caroline Dorothy Klaunberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred E. Phillips - duaghter 7407 Edsworth Rd; Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signa ure - Funeral Service 22. Name and Address of Facility State Anatomy Board monay, 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) OCONGRU Medical uence of Examiner Sequentially list conditions, Examine if any, leading to inimediate cause. Enter Underlying Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant a
Unknown 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 20 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No the Accident Investigation 6 Could not be 3 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and itle of certifier

30. Name and address of person

Susan

lows

FEB 0

JAL

Year.

death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond Elton Landing Day - Zoi 0:32 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 9+ tospice Comic bury 7. Age (In yrs. last birthday) 63 yrs. If Under 1 Year | If Under 24 Hrs **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 218-50-1610 1 M 2 D F Months Country Wicomico Days (Month, Day, Year) Min. **Director** 10 1948 Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Md. Somerset Princess Anne 1 🗆 Yes 2 🛂 No ö 10e Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 10462 Stewart Neck Road 21853 United States 12. Was Decedent Ever in U.S.
Armed Forces? 1968

14 Yes 2 No
If Yes, Give 1974 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Raymond Landing Baltimore, Maryland 21275-0036 1 ☐ Yes 2 ☑ No Specify 1974 Completed 3 Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Elvyn Landing Hilda Bozman Landing Department of Health and Important: If item 27 is many injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice E. Landing - Wife 10462 Stewart Neck Rd., Princess Anne, Md. 21853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 12-12-2011 Salisbury, Md. 4 Donation 5 Other (Specify) Salisbury Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave. Princess Anne, Md. 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Onset and Death Ph sician/ isease or condition MAHGNANT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month the g Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? Yes 2 No death? 1 Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospita ျ 1 Yes Other: P1 4/2 1 Inpatient 2 I ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-12-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vernon R. Lednum State of Maryland / Department of Health and Mental Hygiene 2011 43595 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 0900 hrs December 30, 2011 Vernon Robert Lednum 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3900 Lochraven Blvd **Baltimore** 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 12-21-1921 Country) MD 90 212-18-6426 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10 10c. City, Town or Location 1 Yes 2 X No Talbot McDaniel 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21647 IISA 9672 Tilghman Island Rd items 23a 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Armed Forces? 1 X Yes 2 5 Give Year 1 Yes 2 X No specify: White 4 Divorced Specify: <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h ient of Health and Mental Hygiene. int: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", Baltimore, MD 21215-0036 Fisheries Waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Alice Ferguson Edgar Lednum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ျှ 19a. Informant's Name/Relationship (Type, Print.) McDaniel MD 21647 9672 Tilghman Island Rd Patsy E. Fluharty (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Chesapeake Cremation 1 Burial 2 X Cremation 3 Removal from State tment o 1-4-2012 Stevensville, MD 4 Donation 5 Other Specify. Center Signature of Funeral Service Liven 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601

That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each /Middical Death a Subdural Hematoma with Rebleed Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Repeat Falls Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate ause. Enler Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown dementia, abnormal vision, anemia, HTN, hearing loss, weight loss Completed s certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed Yes 2 ✔ No 1 Yes Hospital or Atteodiog Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Subject fell then fell again 3 wks prior to SDH Certification: FOUND: Natural Director: 5 Pending 1 Yes 2 V No diagnosed in hospital Dec 30, 2011 0855 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be 3 Suicide or Town, State) 9672 Tilghman Island Road, McDaniel, MD determined (Specify) Single Family Home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certific O.C.M.E. December 30, 2011 cek 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 AV + I 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

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	Examin	ler	Civista Medical Cen	1		LC	a Plata		4c. County of De	irles
	Funeral Director		5. Social Security Number 6. Sex 7 6. Sex 7 6. Sex 7	Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	9. E y, Year) -1938 WA	Birthplace (State or Foreign Country) SH D C
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tbht/W	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 2364 ASHFORD DRIVE			10f. Zip Code	603		10g. Citizen of What (Country?
7	eath wi tems 2 er mus	Fune	11. Marital Status 12. Was Deceder		13. V	Vas Decedent of Hi	ispanic Origin? (Spe	cify Yes or No-		nerican Indian,
) 0036	after de al", or i xamin	by	1 ☐ Never Married 2 🔀 Married	No No		f Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, Puerto I Specify:	Rican, etc.)	Black, Wh Specify: WH	, and the second
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nd 2	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	B	12th 17. Father's Name (First, Middle, Last)		1 01	11 0121	18. Mother's Name	e (First, Middle,	WSSC Maiden Surname)	
χ_{enn} Maryland	should be and Menta is marked raumatic e	욘	GEORGE MICHAEL MCN						SE GREEN	
-	d 2 sho alth and 127 is I		19a. Informant's Name/Relationship (Type, Print) ALICE MCNEY-SPOUSE			ig Address (Street a			r, City or Jown, State, 2 RF,MD。 20	
CNeN Saltimore,	permit. Page. 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra	e 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta			sition (Name of natory or other plac		Date	20c. Location - City	
altim	nit. Paç vartmen vortant rinjury			ROPOL,	22.	. Name and Addres	DRY 1-8-		ALEX., VA	
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			23a. Part 1. Enter the disease, or complication and at caus shock, or heart failure. List only one cause on pach I Immediate Cause (Final	ed the death. I	Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between Onset and Death
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D X 08	the Hospital or Attending Physician: The law requires that the death certificate be ex hin 24 hours after death. The second hours after death. the Funeral Director: After this certificate has been signed by the attending physician mpleted filled in by the funeral director, page 2 should be detached for use as the burian		in the past 12 months:	h 2 🗀 Fetal de	leath 3 🗌	Ectopic pregnanc			23d. Date of o	delivery
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, P.O	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death	but not resulting	ing in the ur	nderlying cause giv	en Part I.		1/ _	to the cause of death?
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- Records,	sician: The law i certificate has b lirector, page 2 s	Completed by	- revolution	/				autop perfo	prior to	completion of cause of
Vital F	ician: T certifice rector, p	Be C	25. Was case referred to medical exampler?			Othe	ace of Death (Check		20-110	CS 2 110
of V	g Physical this neral direction	te: To	27. Manyler of Death 28a. Date of in	atient 2 ER	3b. Time of	t 3 L DOA 28c. Injury	4 ☐ Nursing Hor at 2		lence 6 Other (Spe ow injury occurred	ecify)
a sion	tending death. tor: Aft the fur	Certificate:	2 Accident Investigation		Injury		Yes 2 No			
J3a Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s	Cerl	Homicide (determined 28e, Place of I	njury - At home etc. <i>(Specify)</i>	, farm, stre	et, factory, office	2	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
_	Hospita 24 hour Funera sted fille	Medical	29a. Certifier 1 Certifying Physician: To the best control (Check 2 Medical Examiner: On the basis of	f examination a	nd/or investi	igation, in my opinio	on, death occurred at	the time, date a	nd place, and due to the	e cause(s) and manner stated.
	To the within 2 To the comple	Ĭ	only one) 3 ☐ Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ne best of my kn	nowledge, de	eath occurred at the 29c. License	e time, date and place	e, and due to the	e cause(s) and manner a 29d. Date signed (Mor	as stated.
			> Sucho	w		D30	1114		12/30	1/00//
	5		30. Name and address of person who completed cause of	death (Item 23	la) (Type, Pr	C post	to MECS	- Ro	od, was	dorf, Mp
	Stat	e	31. Date filed (Month, Day, Year)	trar's Signature	bar	2	- 80		/	20/02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene state amend 5-22 per fh g923 1/26/12 the Registrar Registrar Rec. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vovember 50 FM Jaxon D. Maresca Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown, MD. Washington Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ₺ M 2 □ F 11⁽¹/9^t/₁, P¹/₁, Year) Hours 5 215 Country MD **Director** Usual Residence of Decedent 28a-f shov 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified PΔ Franklin Waynesboro 1x Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Crown Court 17268 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Infant Infant Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Stephen Maresca Lorraine S. Cloke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Crown Ct., Waynesboro, PA. 17268 Stephen Maresca (father) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Cumberland Valley 11/11/2011 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Grove-Bowersox Funeral Home, Inc. Signature of Funeral Service Licenses James A. Bowesox (per DVR) <u>50 S. Broad St., Waynesboro, Pa. 17268</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sundrome Se quentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? the Hospital or Attending Physician: The law requires that the death 5 Other (specify) Pregnant at time of death Day 2 No Yes signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 2 🗌 No 1 🗌 Yes 1 Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 2 7 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun Natural 5 Pending 1 Yes 2 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier wa

Registrar DHMH 17 Rev 7/2009

State

21742

Hagerstown, Md.

of person who completed cause of death (Item 23a) (Type, Print)
gwana-Mondoa 11116 medical Campus Rd.

32. Registrar's Signature

Theresa Ngwana-Mondoa

JAN 2 6 2012

31. Date filed (Month,

amend 6 per bc. g923. 1/27/12 kh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SABRINA State of Maryland / Department of Health and Mental Hygiene amend 1 per dr. g923 1/26/12 th Certificate of Death 43598 Reg. No. 1. Decedent's Name (First, Middle, Last)
Baby (B) Newman 2. Date of Death 3. Time of Death Physician/ Month NOV Day 9 104-1 Medical Q 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bathmore SINA Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign BAB Yrs. Country) **Director** 0 (AKNOW) 1.1 9 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director アンダス ろ、 1 Yes 2 No ALTIMOR 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 21215 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: and Mental Hygiene. Black Completed 3 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) /⊿infant A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWA ABRINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sabelina Newman - mother 30 +hberT DALTIMORP 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Hospital 101 lz JALMIMORE. 22. Name and Address of Facility 5, NA 21. Signature of Funeral Service Licensee DISPOSAL HOSPITAL OF Baltmore 2401 W. Beluepere Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death XTRE Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last for use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery ☐ Live Birth 2 ☐ Felia Gall
☐ Pregnant at time of death
☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Dav Year be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con Jute to the cause of death? þ 2 Vo 3 □ Probably 4 □ Unknown Be Completed 1 Tyes Were autopsy findings available prior to completion of cause of death? 24a. Was ap After this certificate has funeral director, page 2: autous formed? 2 🕩 1 🗌 Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? -lospita Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be completed filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu 29c. License numbe 29d. Date s gned (Mg nth, Day, Year) Uds

Registrar
DHMH 17 Rev 7/2009

State

30. Name a

31. Date filed (Month, Day,

, Print) 2401 W. Belvedere Ave. Baltimore, Md. 21215

State of Maryland / Department of Health and Mental Hygiene 1/26/12 Certificate of Death amend 1 per dr. g923 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NCV Physician/ Baby (C) Newman 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death
Balt Mol Cu 4c. County of Death Sabeina 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Days Hours 8 **Director** Yrs Country) LUKNOW N Usual Residence of Decedent show 10b. County 10a. State 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f mole 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21215 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Black should be filed within 72 hours after and Mental Hygiene. If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 Widowed 4 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry VOWWIND (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NA NIA infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Newman ANITER Ul. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Hosp. TAL Daltimore 12 10 21. Signature of Funeral Service Licensee D > > > > > A L 22. Name and Address of Facility SINAI HOSPITAL OF 2401 W. Belucacre MD 21215 ve, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXT REM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed After this certificate has prior to completion of cause of death? 2 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 🗌 Yes မ 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director, Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signa 29d. Dat∉ signe (Month, Day, Year) ath (Item 23a) (Type, Print) 2401 W. Belvedere Ave., Baltimore, Md. 21215 State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-09682 Quintin Tyrone Pe		1- For State Certificate of Death Reg. No.	360								
Physiciar Medical Examin		1. Decedent's Name (First, Middle,Last) Quintin Tyrone Perry Jr. 2. Date of Death Month Day Year December 25, 2011 3. Time of D 1345 hr									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's General Hospital Cheverly 4c. County of Death Prince George's	_								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 2. F 23 1. Age (In yrs. last birthday) 2. F 23 2. Security Number 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State Foreign Wa 5 hours Min. 12/08/1988 Foreign Wa 5 hours Min. 12/08/1988 Foreign Wa 5 hours Min. 12/08/1988									
Maryland 28a-f show any d. at once.	Ī	Usual Residence of Decedent 10a. State	-								
n the Maryland 3a or 28a-f sh otified at once		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6707 Riverdale Road #G 20737 USA									
MOCE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. In titlem 71 is marked other than "matural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bi White, etc. 15. Yes 2 No 16. Yes, Sive Year 16. Tyes, Give Year 17. Yes 2 No specify: 18. Race - American Indian, Bi White, etc. 19. Yes 2 No specify: 19. Specify: 10. Yes 2 No specify:	ack,								
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AD 21215-0036 2 should be filed within 7 n and Mental Hygiene. The marked other than matic event, the Medica		17. Father's Name (First, Middle, Last) Quintin Tyrone Perry Sr. 18. Mother's Name (First, Middle, Maiden Surname) Annette Rice									
e, MD 2 and 2 should Health and Mitem 27 is m	19a. Informant's Name/Relationship (Type, Print Father Quintin Tyrone Perry Sr. / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Quintin Tyrone Perry Sr. / 6707 Riverdale Road #G Riverdale, Md2 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State (Street and Number or Rural Route Number, City or Town, State (Street and Number or Rural Route Number, City or Town, State (Street and Number or Rural Route Number, City or Town, State (Street and Number or Rural Route Number, City or Town, State (Street and Number or Rural Route Numb										
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	B۱	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
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Vital Rec bysician: The I this certificate I director, page		25. Was case referred to medical examiner? 1 Ves 2 No 1 No spital: 1 Inpatient 2 Residence 6 Other:									
on of Vi cading Physi ath. or: After this the funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Cocurred 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No 28d. Describe how injury occurred Subject shot									
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	20111120	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Emergency Room Street 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 1. Suicide 4 Phomicide 1. Specify Emergency Room Street 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town, State) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue and Southview Drive, Oxon Fig. 28f. Location (Street and Number or Rural Route Numor Town) Southern Avenue Avenu									
To the Hos within 24 h		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To with		29b. Signature and title of certifier 29c. License number O.C.M.E. December 26, 2011)								

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

DEME

Victor Weedn MD JD

State 31. Date filed (Applie)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amend Items 2	State of Ma 25 ,27,28a -1	aryland/E f per m e	epartme Centrica	nt of H	lealth a /2012 eath	and Me I dhb	ental Hy	giene _{Reg. No}	201	1	43601
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	Director		219–46–6148 Usual Residence of Decedent	⊠ M 2 □ F	63	Yrs. Months	Days	Hours	Min.	(Month, Day 09/22/	y, Year) 1948		Counti	sylvania
	f show	tor	10a. State 10b. County		10c. City, Town								10	Od. Inside City Limits
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9200	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	ed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎦 Divorced	12. Was Decedent E Armed Forces? 1 Pyes 2 I If Yes, Give Year or Dates.	No		edent of His ecify Cubar 2 X No	n, Mexican,	gin? (Specii , Puerto Ri	fy Yes or No- can, etc.)	- 1	14. Race - A Black, N Specify:	White, e	etc.
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Maryland	hould band Mer s mark tumatic		(Ur 19a. Informant's Name/Relationship (7	ype, Print)		Mailing Addre			er or Rural F	Route Numbe	r, City or	Town, State		
e,	and 2 s Health s em 27 i		Brandon Roberts 20a, Method of Disposition	on (Son)		545 #2 Disposition (Na		Bott	tom Ro			inste		MD 21157
Baltimore,	Page 1 ment of tant: If it jury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Arden	y, crematory or t Crema	other place tion		12/16	/2011	На	nover	, MI)
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	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.					cardiac or I	espiratory an	rest,			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Bilatera Due to (or as a	consequence o	f):	Cuie					W		
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\mathcal{ME} . Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 Ectopie 5 Other (у				23d. Date o		ery Day Year
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& <u>2</u>	ng Phys ter this neral di	te: To	27. Manner of Death	28a. Date of injur Found Day,	ent 2 ER/Our y 28b. T : Year)		DOA	at IInkı		e 5 🗌 Resid d. Describe h			Specify)	
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Divi	urs after ral Dire	al Ce	4 ☐ Homicide determined	Unknown	. (Specify)					Unknow	vn, State	·) 		
	n 24 hor n 24 hor ne Fune oletely f	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex se Practitioner to the	camination and/or	r investigation, i	n my opinio	n, death oc	curred at th	ne time, date a	and place	e, and due to	the cau	use(s) and manner stated.
	To the vithii To the comp		29b. Signature and title of certifier	MD		1	9c. License	number 569'	20,			te signed (A		Day, Year)
	1		30. Name and address of person who	completed cause of de		Type, Print)								
	Stat	0	22 South Green 31. Date filed (Mg)AN 202 P 201	e Street,	Battimor	re, Mari	land	21201		5hr	uti	RA	jA	mD.
	Registra	ar	JAN & 1 20	Lengua	r's Signature	aure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 9 2011 4:10 P_{M} Joseph Edward Smith Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Catonsville Manor Care Woodbridge Valley 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year ine 5 . 19 1 💢 M 2 🗆 F 83 220-20-5269 Maryland **Director** June Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21207 3226 Elba Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 194 If Yes, Give Year or Dates. 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1947þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Specify: Completed 3 - Widowed 4 - Divorced 1950 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) warehouse foreman US Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Smith James Waters 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3226 Elba Drive; Baltimore, MD 21207 Elizabeth Smith - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RIENSIVE CARPIU VASCULAR disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? USTEUMYELITIS Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy r this certificate ha 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending nours after death. neral Director: Aft I filled in by the fur 1 Yes 2 No M Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

3 29b. Signature and title of certifier

31. Date filed (Month,

MA

FEB 0 1 2012

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210 Busness

32 Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

W59107

CENTER PRIVE

29d. Date signed (Month. Day, Year)

REISTERSTOWN MD 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 31. Physician/ Month Irene Stambler 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House 8. Date of Birth
(Month, Day, Yea
Nov. 30 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours Min Director 090-24-1882 89 Germany Nov. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location Director MD Montgomery Bethesda 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 20817 United States 7026 Wilson Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify:White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. Temporary Employment life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agency Self Proprietor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Bruno Henius Kaithe Landsberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace 7952 Mayfair Circle, Ellicott City, MD 21043 Jill Rosloff/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University
Medical Center 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Dec. Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Servics, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) a. Pulmonary Fibrosis
Due to (or as a consequence of): Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence by requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 e attending ph d for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 🗍 Unknown is been signed by the should be detache P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by **Emphysema** Records, 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 🗌 Yes 4 Nursing Home 5 Residence Of Other (Specify) Hospice 27. Manner of Death 28a. Date of injury 28b, Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending 1 Natural 1 Yes 2 No ☐ Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

1355 Piccard Drive Suite 100

Rockville, MD 20850

R143201

3. Time of Death

10d. Inside City Limits

Approximate

29d. Date signed (Month, Day, Year) January 12, 2012

Onset and Death

1 ¥ Yes 2 ☐ No

7:28 P.M

To the Hospital or Attending Physician: Division of Vital this nours after death. neral Director: After that filled in by the funeral within 24 hor To the Fune completed fi

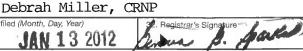
Certificate:

Medical

29b. Signature

State Registrar 31. Date filed (Month, Day, Year) JAN 13 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2-16-2011 Physician/ Richard Caldwell, Sr. 9:05 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HCR-Manor Care Prince George's Largo 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Hours Min. 578-30-0083 85 04^M7th1926^{ear)} **Director** Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10d. Inside City Limits must be notified MD Prince George's 1 X Yes 2 No Mt. Ranier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 Queen's Chapel Road, Apt. 101 20712 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 ☐XNo Specify: Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cab Driver Private Industry Caldingulmuam Baltimore, Marylang 21 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Farl Caldwell Clara Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Caldwell, Jr./son 3001 Queen's Chapel Road, APt. 101, Mt. Ranier, MD 20712 Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of F Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Mem. Cemetery 12-23-2011 Suitland, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH, 4111 Pennsylvania Ave., Suitland, MD 20746 18ha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Cardiopulmonary Failure Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year 1 Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 2 🗌 No **Division of Vital** 25. Was case referred to medical B B 26. Place of Death (Check only one) ည 1 ☐ Yes 2 ☐ No 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in t City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, each occurred at the time. Jate and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check 29b. Signature a tle of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

1328 Southern Ave., SE, Washington, DC 20032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, MD

51520

12-23-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 30, 2011 10:50 A M JEROME FREDERICK CONNOLLY, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner OUEEN ANNE'S** 210 KINGSDALE FARM LANE QUEEN ANNE If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 216-14-2091 1 **X** M 2 □ F 93 OCT. 25, 1918 MARYLAND show aţ 10c. City, Town or Location Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Tes 2 X No QUEEN ANNE'S **QUEEN ANNE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 210 KINGSDALE FARM LANE 21657 be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **FARMER FARMING** -0-12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES CARROLL CONNOLLY, SR. ANNA SLAUGHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 210 KINGSDALE FARM LANE, QUEEN ANNE, MD 21657 MARIE CONNOLLY/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 🖫 Burial 2 🗌 Cremation 3 🗌 Removal from State JAN. 3, 2012 ST. JOSEPH'S CEMETERY 4 Donation 5 Other (Specify) CORDOVA, MD Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition war Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 W To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 👿 Residence 6 C Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funer Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) egistrar's Signature State parko

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Tieffa Dec. 28, 2011 1:40a_M Elias Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Carriage Hill Nursing Home Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1/17/1913 578-10-3008 98 Wash., DC **Director** 1 □ M 2 🛂 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director Md Bethesda Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5215 West Cedar Lane 20814 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Nicholas Atohi Aman Neam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4021 N.27th Street Arlington, Virginia22207 Laurice Neam/Executrix 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cem 1/18/2012 Arlington, Virginia 4 Donation 🔏 🗌 Other (Specify) 21. Signature 🐧 PHTE TPACTOS RENALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 e, isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart Immediate Cause (Final Onset and Death Physician/ CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 Yes 2 ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 DNo **Division of Vital** Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/30/11

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao MD

JAN 18 2012

31. Date filed (Month, Day, Year

10057124

10110 Molecular Dr #206 Rockville, Md 20850

 \cancel{KOMe} *stat* $_{I}$ *William* Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 Will or Attending Physician: The law requires that the death certificate he executive

			Please	Type or Pri						-		_	€.
		For _ State		State of Ma	arylan					Mental H	ygien	e mil	1121008
		Registrar					Certifica	te of De	ath		Reg. N	0.0011	43000
Physicia Medic		Decedent's Name WILL		^{st)} BIN KOMEST.	AT,	JR.				2. Date of I		39 201	3. Time of Death M
Examin Funeral Director	er	4a. Facility Name (if the Control of	Anne 6. s 117	Emerger	OU e (In yrs) la 78	Geriast birtho	lay) If Und	Que er 1 Year If	enstruction of Death enstruction (Min. 1997) Under 24 Hrs. Jours Min.	wn	Birth	c. County of De QUEE 9. E 933 N	eath Ane Birthplace (State or Foreign
nd how at	۱	Usual Residence of I 10a. State	Decedent 10b. County		10c. City	y, Town c	or Location			_			10d. Inside City Limits
/laryla 8a-f s tified	Director	MARYLAND	OUEEN	ANNE'S		GRAS	ONVILL	E					1 🗆 Yes 2 🔀 No
aor2 aor2 beno	io le	10e. Street and Num	ber				10f. Z	ip Code			10g. C	Citizen of What (Country?
th with ms 23 must	Funeral		POINT R	T				1638			_	UNITED	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ GARY LYNN SPENCER 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland Birthplace (State or Foreign Country) Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 234-78-8323 1 🕱 M 2 □ F 63 July 5,1948 Cumberland, MD 28a-f shov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 👿 No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rt. 1, Box 134 26726 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 No X Yes Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 🗌 Widowed 4 🔀 Divorced Completed Year or Dates. Vietnam White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Dept. Tire Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin E. Spencer Olive B. Streets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Penny L. Stickley/Executrix Box 6518 6, Keyser, WV 26726 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Dec. 29,201 4 ☐ Donation 5 ☐ Other (Specify) Keyser, WV Funeral Home Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licen: Smith Funeral Home S. <u> Main Street</u> Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Diray disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical monav Division of Vital Records, P.O. Box 68760 attending ph d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 **N** No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eletely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within Z 29d. Date signed (Month, Day, Year) 0067876 28 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrook Rosd Manohar Chenchugalla, Hospitalist Cumberland, MD 21502 31. Date filed (Month, Day, Year) Registrar's Signature State FEB_0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Clarence Cephas December 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Dulaney Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) unk Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Feb 19, Year) 1956 Director 219-70-2566 1 XM 2 - F 55 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No MD Baltimore Towson ō 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 111 West Rd. 21204 USA within 72 hours after death 11. Marital Status **unk** 12. Was Decedent Ever in U.S. UTI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. 14. Race - American Indian, Black, White, etc. Examiner 9 ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: black "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation **Unk** (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry ລe filed wn. ຳal Hygiene. ்∾r than "r (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) the unk unk and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 111 West Rd; Towson, Maryland 21204 item 27 Manor Care - Dulaney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state cemetery, crematory or other place Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death MVOS Physician/ mune Medical Examiner 0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -trans that initiated events resulting in death) Last attending physician a for use as the burial-/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page (performe Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, n 24 hours after death.

e Funeral Director: After the older of the funeral older. 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year) D 5274

State Registrar

overne

7503 aster Drik, Towson,

of person who completed cause of death (Item 23a) (Type, Print)

SIRPARA MO

8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,15a&b,17&18 Per ANA BD G923 1706/2011 JH State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 12:11PM naron 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death - Manyland Medicalcen Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Jan 2, 1947 9. Birthplace (State or Foreign Couptry) unk Maryland 5. Social Security Number-**Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗓 F Months Yrs. **Director** 214-46-1679 64 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 No MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9326 Ourtime Ln. 21045 USA 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: "natural", XX Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation **UTIR** (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0 12) th and Mental Hygiene. 27 is marked other than traumatic event, the Me College (1-4 or 5+) -unk unk Teacher EDucation Be 18. Mother's Name (First, Middle, Maiden Surname) Unk 17. Father's Name (First, Middle, Last) unle ပ္ Calvin Edmon Shenton Bette Margaret Barton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Jennifer Gleaves - daughter 975 OLd Woodbine Rd. Woodbine, Md 21797 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state KOII 1 C S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No Yes 2 No 1 Yes To Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 962727 12/30/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tha Gupta, 27 S. Greene St. Baltimore, MD 21201 22 pla State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Isabelle Edwards December 5:00 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FoxChase Rehab Center Montgmery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) ug 30, 1919 1 M 2 X F Months Days Hours Min. New York Director 92 577-28-9516 Aug Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA Funeral 20910 2015 E. Way Hwy. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 **black** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) private homes domestic worker Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 900~G~Street~NE~#526 , Washington, DC 20002Department of Health ar Important: If item 27 is any injury or other trau Evelyn Delillye - friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State state 4 Donation 5 Other (Specify) in Ronal Service Licepted (22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Year Teart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) dementia - advanced Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Ectopic pregnancy n/a 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 H Unknown Completed hypothyrodism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law I autopsy performed? Yes 2 N 2 🛚 No 1 Tes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: ဂ္ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) fter death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending injury Division 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours of To the Funeral Discompleted filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated signature and title of certifie 29d. Date signed (Month, Day, Year) DNA 1/20/12 D28656

State Registrar 32. Registrar's Signature

15245 Shady Grove Rd #130; Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Passi, MD

31. Date filed (Month, Day, Year) FEB 0 8 2012

Ravî

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical Name (if not institution, give street and nu-**Examiner** County of Death 8. Date of Birth (Month, Day, Year) **Funeral** 9 Birthplace (State or **Director** or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1425 Cameron Rd. 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation UNK 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000~McComas~Ave;~Kensington,~MD~20895Kensington Nursing & Rehab 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board e of Funeral Service License 655 W. Baltimore St; Baltimore, MD 21201 oter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dona disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician I be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregr 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 1 Yes 2 No 3 Probably 4 Onknown should 24a. Was ar 24b. Were autopsy findings available has page 2 autopsy performed prior to completion of cause of death? After this certificate 1 Yes 2 No To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to dical æ 26. Place of Death (Check only one) examiner? 10 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No after death Accident Investigation M 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certif des 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMMER WALK DR. GATTHERSBURG 743 SHARMA SANDEEP State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Mary A. Mulbauer December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 4573 Powell School Rd. Parsonsburg Social Security Number f Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Oct 22, 1927 1 □ M 2 🕅 F Min. Maryland **Director** 84 217**-**26-2848 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Wicomico Parsonsburg 10g. Citizen of What Country? 10e. Street and Number ò 10f. Zip Code 21849 pe by Funeral 4573 Powell School Rd. 23a items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedon ___ Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 healthcare secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Rudolph Mary Anna Svec I and 2 should by Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 4573 Powell School Rd; Parsonsburg, MD 19a. Informant's Name/Relationship (Type, Print) D 21849 Janet Prudy - daughter Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or sear fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aMAHANANT NROPLASM OF UNKNOWN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence on Examir Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 e Hospital or Attending Physician: The law requires 24 hours after death.

24 hours after death.

Funeral Director. After this certificate has been sign leted filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No I ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2005 84(0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 130 V

6:35

1 🗆 Yes 2 No

AM

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20b Per FH C923 1/12/2012 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ecomber Physician/ 46 P.M Sandra Jean Staley 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORE 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖵 F Months Hours Min. Month, Day, Year) 54 Country) 216-62-3901 57 Jan MD **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21229 USA 629 LUCIA AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed BLACK Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RECON CLERK SOCIAL SECURITY ADMIN. Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eveni once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN E. RICHARDSON RUTH IRENE ALSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES DENNIS STALEY-SPOUSE 629 LUCIA AVE. BALTIMORE, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/13/2012 cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Owings Mills, MD 1/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March FH West BAltimore, MD 23a. Pait 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Throat Known Medical Du to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2: autopsy performed No 1 Yes 25. Was case referred to medical funeral director, Be B 26. Place of Death (Check only one) examiner? Hospital Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural safter death.

I Director: Aft
d in by the fur 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination allows invosing a continuous and some states.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ellen Harris Solomon 6:57 P M November 2011 6. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 □ M 2 🗓 F Months Days Hours Min. Philadelphia, Director 97 176-26-7364 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 🗌 Yes 2 ី No Bethesda 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral 8201 Bryant Drive 20817 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 🗓 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Caucasian 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson other 1 Furniture Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of r traumatic ever ၉ Harold R. Harris permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Alice Selig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Harvey Solomon, Son 8201 Bryant Drive, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Loudon Park Crematory 11/9/2011 21. Signature of Funeral Sen de Licensee 22. Name and Address of Facility Simple Tribute M01102 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Cardiomyopathy</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): P.O. Box 68760 C. that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be law requires Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 2 😿 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 I 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

cilleg

0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

743 Summer Walk Drive, Gaithersburg, Maryland 20878

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Records,

Division of Vital

D0064624

Sandeep Sharma, MD

29d. Date signed (Month, Day, Year)

11/8/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per phy, g924 2-9-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Day Month 6:15p м 1artha <u>_</u>. 12/30/2011 Medical 4a. Facility Name (if not institution, give street and nur Examiner 4b. City, Town, or Location of Death 4c. County of Death 1312 E. Monument St. Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 245-56-6439 **Director** 1 M 2 X F 0 N.C. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1312 E. Monument St. 21205 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Cook N/A Restuarant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Simmie Smith Ruby McLawhorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Sparkman-Daughter 1312 E. Monument St. Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
King Memorial Pk. 1/7/2012 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funera der ce Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ to Stage 4 Medical resulting in death) Due to (or as a consequence of): ~ Dosteon-ili Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 Month Day Year Pregnant at time of death the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes No 3 Probably 4 Unknown is certificate has been sig director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Tyes 3 □ DOA 1 🗌 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural Accident 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1312 Morsonent Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only on Signa 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State

Registrar

Jalecxa Aponte	State of Maryland / Department 1- For State Certificate Registrar		lygiene	3(0)X						
Physician/ 1. Decedent's Name (First, Middle, Last) Anoth Day Year November 21, 2011 3. Time of North Day Year November 21, 2011 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Glap Burnie Anoth Anoth Day Year November 21, 2011 4c. County of Death Anoth Anoth Anoth Purple										
)	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Location of Deat Glen Burnie	h 4c. County of Death Anne Arundel							
Funeral Director		If Under 1 Year If Under 24Hr Months Days Hours Min	n. Foreig	thplace (State or In Puerto Ric untry)						
nd show any scs.	Usual Residence of Decedent 10a. State	eation		10d. Inside City Limits 1 Yes 2 X No						
n the Maryland 3a or 28a-f sh otified at once	10e. Street and Number 8229 Stewarton Court	10f. Zip Code 21144	10g. Citizen of What Cour							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Menlar Hygiene. Important: If fitem 27 is marked other than "astural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Vas Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	can Indian, Black, White						
5-0036 ed within 72 hours aft stygiene "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life. DO NOT use ret surance Agent	work done 16b. Kind of Business/I							
1215-00 is be filed wid sental Hygien arked other went, the Merowent, the Merowent, the Merowent, the Merowent is be Com	17. Father's Name (First, Middle, Last) Gumercindo Colon	18.Mother's Name	e (First, Middle, Maiden Surname) Vidot							
MD 21 and 2 should alth and Me m 27 is ma a sumatic en	Carmen Aponte / Sister 8229	Stewarton Court	Rural Route Number, City or Town, State, , Severn, Maryland	21144						
timore, T. Pages 1 ar Timent of Hee reant: If ite	1 Burial 2 Cremation 3 X Removal from State crematory or Greenwood	od Cmetery 11,	Date 20c. Location - City or 28/2011 Allentown,	PA						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	107 WIlkens Avenu	ubbard Funeral Home ue, Baltimore, Mary or respiratory arrest, shock, or heart	Inc. Land 21229 Approximate Interval						
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. $ \underbrace{NARCOTIC}_{\text{Due to (or as a consequence of):}} $	PHINE) INTOXICATI	ON	Between Onset and Death						
ami i	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last United Exercises (Constant of the Constant of the C									
the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	FEMALE: 30. Was decedent pregnant in the past 12 months? AMENDED 23A, 27, 28A-F, PER 23c. If yes, outcome of pregnancy 1 Live birth 2 Fegnant at time of death 5 General Street of the pregnant at time of death 5 General Street of the pregnant at time of death	ME G925, 3/15/12 retal death 3 Ectopic pregnate there (Specify)	23d. Date of delivery	ay Year						
Is, P.O. Barutine de particles that the de particle by the find be detached find by Physical By Physic	Part il. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the second of the secon	ably 4 🗹 Unknown						
of Vital Records, P.O. ng Physician: The law requires that th wher this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P	No. 1995		autopsy prior to condeath? 1 ✓ Yes 2 No 1 ✓ Yes	opsy findings available ompletion of cause of						
Division al or Attendia s after death. A Director: A ed in by the fi	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No 28a. Date of Injury (Month, Dey, Year) 28b. Time of (Month, Dey, Year) 28c. Place of Injury - At home, farm, str. determined 28c. Place of Injury - At home, farm, str. determined 28c. Place of Injury - At home, farm, str. determined	Injury 28c. Injury at Work? 5 AM 1 Yes 2 X No set, factory, office building, etc.	g Home 5 Residence 6 Other: 28d. Describe how injury occurred JNK 28f. Location (Street and Number or Rur	al Route Number, City APOLIS RD						
2 # 2 # L	9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence) 2 Medical Examiner: Dn the basis of examination and/or investig and manner stated.	rred at the time, date and place, and	due to the cause(s) and manner as stated	i. cause(s)						
	9b. Signature and title of certifier Signature and title of certifier Signature Sig	29c. License number O.C.M.E. GCM	29d. Date signed (Mont November 22, 20							
4 per	Theodore M. King, Jr., MD. Assistant Medical Examiner 1. Date filed (Month, Day, Year) 32 Registrar's Signature	900 W. Baltimore Street, Ba	altimore, MD 21223							
Registrar DHMH 17 Rev 1/2001 OCME 2006	FEB 2 9 2012 Janua B. Janua B. Janua	Mal								

Victor Brian Banks 11-05937 Please Type Print in Black Indelible Ink. Ensure All ies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Ban Month Day August 7, 2011 M⊸dical Examiner 2055 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1835 University Boulevard Langley Park Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Days Hours 215-25-6014 1 X M 2 F 26 6/ Usual Residence of Deceden 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No other than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at once, olleg ilmore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, "attert of Health and Mental Hygiene atter than "natural", in Heast 23a or 28a-f shu and the Tranmaite event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 20740 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: Specify: Black Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Employee Governo 17. Father's Name (First, Middle, Last Pos Be 5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleg Mother 20a, Method of Disposition 20b. Place of Disposition (Name of centetery, Baltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Ikerson Donation 5 Other Specify 22. Name and Address of Facility March P/H E98+ Bilto. 1202 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Asphyxia due to Hanging nediate Cause (Final disease .**≜**xaminer condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown After this certificate has been signed by the sumeral director, page 2 should be detached fr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred FOUND: Subject hanged himself Natural d in by the f 5 Pending within 24 hours after death.

To the Funeral Director: 1 Yes 2 ✔ No Aug 7, 2011 1630 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗹 Suicide Could not be or Town, State) 1835 University Boulevard, Langley Park, MD determined (Specify) Behind strip mall Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated In the 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar

31. Date filed (Month, Day, Year)

2. Registrar's Signature

ŐRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23 artiff, 23 y 27 d 28 art per me, 8924, 324 Mental Hydiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Juanita Duffy Physician/ 74D 201 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care Homewood Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, Social Security Number **Funeral** 6. Sex Months Days Hours Min. (Month, Day, Year) **Director** 251-32-9939
Usual Residence of Decedent 1 M 2 X F 90 5 01 1921 S. C. ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director MD N/A Baltimore 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21213 USA Lakewood #204 1400 N. or items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry ould be filed within 72 m and Mental Hygiene. is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Nursing unkwn item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Rogers Mary Rogers should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Vice-Sister 2528 Ashland Ave. Baltimore, MD 21205 and 2 s Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/7/2011 Baltimore, MD Zion Cemt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, APPROVED BY MEDICAL certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 use Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Left Leg Fracture Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 2 No Yes 2 N 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dia After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 X Accident 5 Pending 1 ☐ Yes 2 X No Motor Vehicle Accident Unknown Unknown Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown location New York 4 Homicide determined Unknown Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sig

State Registrar

01 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #9,11,12,15,16a&b,17,18&19a&b Per ANA BD 6926 4/23/2012 Jh State of Maryland Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g924,02/15/2012dhb
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9, 201 T Johnny Joyner 8:59 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Months | Day, 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 The Country Co Aug 8, 1949 **Director** 240-82-0032 62 1 🛛 M 2 🗆 F North Carolina Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2601 Bel Pre Rd. 20906 USA 11. Marital Status unk Was Decedent Ever in U.S.unk
 Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces?
 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. black 1 ☐ Yes 2 X No Specify 3 Widowed 4XXDivorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk 12 unk 4 Tire ironing Construction Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Brown Eddie Joyner 19a. Informant's Name/Relationship (Type, Print)

Jameka Joyner-daughter P. OaiBox 7349173 announter Chesterrield, Tovasta 232340 Montgomer General Hospital Prince Phillip Dr; Olney, MD 20822 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In State cemetery, crematory or other place, pureral Service License On a Living ulire Juneral Serv Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Kespin disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed FICATION APPROVED BY Due to (or as a onsequence of) nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No
9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1X Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Porner Philip Dr Olney 18101 32. Registrar's Signature State Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Willard Romeo Johnson Sr. g02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Accokee</u>k P.G. 17310 Summerwood Lane If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours 2-1 0-1945 Yrs washington DC **Director** 578-58-5158 66 Usual Residence of Decedent 28a-f shov State 10b. County 10c. City, Town or Location Accokeek must be notified at 10d. Inside City Limits Director P.G. 1X Yes 2 ☐ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 20607 USA 17310 Summerwood Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 6 þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) <u> Management Analysis</u> Education traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johnella Boyd Clarence Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh
Department of Health as
Important: If Item 27 is
any injury or other trau 20607 Shirley A. Johnson/wife 17310 Summerwood Ln. Accokeek MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial Denati 2 Cremation 3 Removal from State Maryland Veterans 1-19-2012 Cheltenham, MD mation, 5 Dither (Specify) 21. Sign 22. Name and Address of Facility Wiseman Funeral Home 20735 Old Alexandria Ferry Rd Clinton MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 18 metand Peaths Physician/ Acute Myeloid Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death Day signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 No Other: 1 🗌 Yes ဂ္ဂ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) e Hospital or Attending Pt 124 hours after death. e Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a vithin 24 hours a To the Funeral Completed filled in the completed filled filled in the completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2150 Pennsylvania Ave. NW 1-100 Washington DC 20037 abbarz 31. Date filed (Month, State

DHMH 17 Rev 7/2009

Registrar

			Please I amend I tems Registrar Amend #11 Pe 1. Decedent's Name (First, Middle, Last)	ype or Pri	nt in Bla 16,19a aryland /	ack In Depa	delible Inl a-c,22, rtment of I	k. Ensure g 924 2–2 lealth and	All Copie: Mental Hyd	s Are Leo	gible.	
		-	1 - State Amend Items Registrar Amend #11 Pc	23aPtI,I	1,27,2	.8a-£ / 1	ificate of L	924,027 Seath	16/2012a	$\mathbf{h}\mathbf{b}$ Reg. No. $2\!$	11-4	3623
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	Examin	er	4a. Facility Name (if not institution, give stre St. Thomas More N				4b. City, Town, o	r Location of Deatl	h	4c. Count		orge's
	Funeral		Social Security Number 6. Sex	7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs		h	O Diebe	lass (Ctata au Faurina
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	death item		Tr. Wanta States	. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ	
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	d by	1 ☐ Never Married ② Married 3 ☐ Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Dates.	No	1	X Yes 2 □ No	Specify: me	exican	Specify		nispanic
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Bal	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee ROTTald S	de Dir	etor	S t	Name and Addre	ss of Facilit Mue omy Boar MD 212	d 655 W.	H. 314 Baltin	W. 18	treet
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	Physician/		shock, or heart failure. List only one of Immediate Cause (Final	cause on each line	Mult	tiple	Injurie	s with C	omplicat	ions		Interval Between Onset and Death
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	To the within 2 To the comple	ž	only one) 3 Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the	best of my kno	owledge, d	eath occurred at the			e cause(s) and m 29d. Date signe		
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	with the 23a or ust be n	Funeral Director	10e. Street and Number 7 Honeysuckle D	rive			10f. Zip	Code 1904	ŀ			10g. Citizen of Unit	what Cou	-
36	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🙀 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give	X No	I1	Vas Decede f Yes, speci	fy Cubar	n, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		ack, White,	
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۵	Hospi 24 hou Funer tely fill	Medical	(Check Medical Exa	hysician: To the best aminer: On the basis o lurse Practitioner: To	f examination	and/or invest	igation, in m	ny opinio	n, death oc	ccurred at t	he time, date a	and place, and d	ue to the ca	ause(s) and manner stated
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	4		30. Name and address of person wh	no completed cause o	f death (Item		Print)	(-7-1 C		St.	D. III		MD 21201
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	1	State of Maryland / Department	cate of Death	2. Date of Death	3. Time of Death
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/Medical			City, Town, or Location of Death		4c. County of Death
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			Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
neral ector		237–74–0475 1)XI M 2 🗆 F 63 Yrs. Mo	onths Days Hours Min.	(Month, Day, Yea 4–26–1948	N.C.
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rihan 'natural, or tems 23a or 28a f snow tre Modical Examinational be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
e la la		1 Never Married 2 M Married 1 □ Yes 2 No	Yes 2 No Specify:		Specify: Black
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		shock, or heart failure. List only one cause on each line.			Onset and Death
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eral (Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how	injury occurred
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Dire	Certification;	4 ☐ Homicide building, etc. (Specify) Found: Hospital		Avenue, B	altimore,MD
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only 2 Medical Examiner: On the basis of examination and/or invest	ccurred at the time, date and plac tigation, in my opinion, death occ	e, and due to the cau surred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
Funera	Med	one) and manner stated.	29c. License number	290	I. Date signed (Month, Day, Year)
the Funera		29b. Signature and title of certifier		22 1	1/25/2011
To the Funeral Director: After this certifical completely filled in by the funeral director.		P TANKA IN A DAMMARWA	D V V TUC	3 L	(4) 40 1
To the Funera		To the Time of the	000108		
To the Funera		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince)	int)	C	Balt
To the Funera completely fille		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince of the Complete of Cause of death (Item 23a) (Type, Prince of Cause of death (Item 23a) (Type, Prince of Cause of Ca	nt) NU 821 N	EUTAN	ST # 34 Ball

11-09617 John Sullivan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Month Day December 22, 2011 Medical Examiner 1422 hrs John Andrew Sullivan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23733 Solitude Drive Henderson Caroline 5. Social Security Number 7 Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Maryland Director Months Davs Hours Feb 28 1972 218-90-8734 1 X M 2 F 39 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or items 23a or 28a-f show Maryland Caroline Henderson 72 hours after death with the Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23733 Solitude Drive 21640 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 XDivorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: White "natural", ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collage (1-4 or 5+) traumatic event, the Medical Baltimore, MD 21215-0036 is marked other that Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. construction Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Glen Arnold Sullivan, Sr. Ruth Carol Schmaldienst ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Lobloy Drive; Ruth C. Schmaldienst/ mother Seaford, DE If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State rtant 4 Donation 5 Other Specify: Chesapeake Cremation 27 201 Stevensville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA Susan R. Fleegle Per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Chronic Obstructive Pulmonary Disease(COPD) xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical AMENDED 21, per fh, 23a, 27, per me, g924 2-29-12 sm X UNPENDED s attending physician for use as the burial The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other of prifficent conditions—contributing to doalin but not resulting in the underlying cause given in Part I. P.0. CCa. Did tobacco use contribute to the couse of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Records. 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed' Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other Scene this ER/Outpatient 3 DOA 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the tropping within 24 hours after death.

To the Funeral Director: A 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registra

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			Amend Items 28e,	Type or Pringer me	nt in B	Jack Indeli	ble In	k. Ensure	All Copie	es Are Leg	jible.
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	/arylanc 8a-f sho tified at	rector	10a. State 10b. County Balti	more	10c. City,	Town or Location Dundal	k				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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Baltimore,	Page 1 a lent of H nt: If ite ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Dopation 5 □ Other (Speci	Removal from State	20b. Placen	ce of Disposition (N metery, crematory of QHeartof	lame of Lother place Jesu	is 12	Date /15/11		City or Town, State MOre MD
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Rec	n: The law icate has r, page 2 s		Gastrostony	Tube F	pec	215			1 Yes	ormed?	orior to completion of cause of death?
Vita	ding Physician: The lath. th. After this certificate hatfuneral director, page	To Be	AL tes 2 A to) Hospital: 1,XInpatie	nt 2 🗆 EF	3/Outpatient 3 □	Othe	er: 4 Nursing H		dence 6 Othe	er (Specify)
on of	nding P ath. :: After ti e funera	cate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day 06/14/2		Bb. Time of injury Unknown	28c. Injury work			how injury occurre	ed
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun	Certificate:	3 Suicide 6 Could not b 4 Homicide determined		y - At home (Specify)	e, farm, street, facto			28f. Location (3	Street and Number	r or Rural Route Number, 58 St. Claire e, Dundalk, MD
	e Hospit 124 hour e Funera leted fille	Medical	(Check 2 \(\subseteq Medical Exami	sician: To the best of manual representations of example and the basis of example and the basis of the basis of the basis of example and the basis of the basis o	amination ar	nd/or investigation, i	n my opinio	n, death occurred a	nd due to the ca at the time, date a	ause(s) and manne and place, and due	er as stated. to the cause(s) and manner stated.
	To the comp		29b. Signature and title of certifier	Se Fractioner. To the D	St of flly ki		9c. License	number		29d. Date signed	(Month, Day, Year)
U		-	30. Name and address of person who	completed cause of dea	ath (Item 23	3a) (Type, Print)		1438			4 12,20H
	Stat		30. Name and address of person who on the state of the st	32. Registrar				מת, בי	2122	4	
	Registra		FEB 1 6 20		J A.	back	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene me, g924,02715/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 EIGLER Physician/ CHARCES De ienher 7134 M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MERYTUS MEDICAL CENTER HAGERSTONN WIASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 🗆 F Months 530-36-8060 Director 61 Oklahoma 105 Usual Residence of Decedent show 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 14014 Marsh Pike 21742 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner rmed Forces?

X Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Vietnam 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Guard Security permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Coy Church Zeigler Lois Imogene Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25427 34 Grindstone Drive Hedgesville, West Virginia Diana Johnson (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State December 4 Donation 5 Other (Specify) Smithsburg Crematory 30, 2011 Smithsburg, Maryland 21. Signature of Funeral Service Licenses J.L. Davis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY ACIDOSIS disease or condition ≱Medical Examiner resulting in death) THEICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): HYPERCAR BIA 12 HRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of): PULMONARY EDEMA the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last 24 HRS and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be 72 HRS INFECTION Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ğ BUTTOCK Division of Vital Records, MASSIVE WOUND 500 cm 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen PARAPLEGIA . Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has I autopsy performed? Yes 2 No URINEARL TRACT INFECTIONS this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ည 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natriral within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1983 1 Yes Subject was shot Unknown 2 **X** No Accident Investigation
6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **California** 4 Homicide determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) D0038466 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 324 E. ANTIETAM ST. SUITE 303 21740 RRYEH HERRERA 31. Date filed (Month, State Day, Year FEB 1 6 2012

Registrar

11-09368 Mark S. Salvetti

Mark S. Salvetti	State of Maryland / Department 1- For State Registrar Certificate		ygiene Reg. No. 2011 -	43629
Physician/ Medical Examine	Mark Steven Salvetti		2. Date of Death Month Day Year December 12, 2011	3. Time of Death 2159 hrs
A CONTRACTOR OF THE PARTY OF TH	4a. Facility Name (if not institution, give street and number) Dorchester Hospital	4b. City, Town, or Location of Deatl Cambridge	Dorchester	
Funeral Director	5. Social Security Number 214-82-8825 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 53) If Under 1 Year If Under 24Hrs Months Days Hours Mir	1 Forei	rthplace (State or gn puntry)Wash DC
eath with the Maryland items 23s or 28s-f show any ust be notified at once.	10a. State 10b. County 10c. City, Town or Lo MD Caroline Greensb 10e. Street and Number	OTO 10f. Zip Code	10g. Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 No
fter d	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decer	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: dent's Usual Occupation (Give kind of v	Rican, etc.) White, etc. Specify: vork done 16b. Kind of Business/	
21215-0(136 Muld be filed within 72 hours a Mental Hygiene. marked other than "matural e event, the Madical Examin To Be Comppleted by	Elementary/Secondary (0-12) College (1-4 or 5+) 1 1 17. Father's Name (First, Middle, Last)	g most of working life. DO NOT use reti sabled	(First, Middle, Maiden Surname)	
MD 21215-0(i d. 2 should be filed with that and Mental Hygene n. 27 is marked other a numstic event, the Marante To Be Com		ling Address (Street and Number or F	ne Meadows Salvetti Rural Route Number, City or Town, State Greensboro, MD 2163	e, Zip Code)
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic. To	20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State crematory or	position (Name of cemetery, other place)	Date 20c. Location - City or 20 201 Stevensvil	Town, State
Baltin permit. J Departm Imports injury or	21. Signature of Funeral Service Licensee F.	Name and Address of Facility 106 leegle and Helfent	W. Sunset Ave. Greein Funeral Home	ceensborg, M
Physician /Medical 	23a. Part I Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause A wind Drug (Oxyc Cyclobenzaprine) Due to (or as a consequence of): Due to (or as a consequence of):	odone. Phencyclid	respiratory arrest, shock, or heart	Approximate Interval 8etween Onset and Death
n and - transit cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
ecords, P.O. Box 68760, he law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - trans ompleted by Physician/Medical E.	Pregnant at time of death	Fetal death 3 Ectopic pregnar Other (Specify)	23d. Date of delivery	day Year
ords, P.O. Be vequires that the despensioned by the should be detached oldered by Physical	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to t	
1			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	topsy findings available completion of cause of s 2 No
C # . ~ # 7	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Danding (Month, Day, Year)	f Injury 28c. Injury at Work?	nly one) Home 5 Residence 6 Other: 28d. Describe how injury occurred	
Division o To the Hospital or Attending within 24 hours after death. To the Fuoeral Director: Aft completely filled in by the fune ledical Certification:	Accident Accident Suicide Homicide Accident Accident Suicide Homicide Accident Accident	eet, factory, office building, etc.	unknown 28f. Location (Street and Number or Run or Town, State) 303 Bunko Cambridge, Md.	al Route Number, City er St. Apt.
To the Ho within 24 Ro the Fu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	surred at the time, date and place, and plac	due to the cause(s) and manner as state	d cause(s)
	29b. Signature and title of certifier Panyolu G Valhall, MD	29c. License number O.C.M.E.	29d. Date signed (Mon December 13, 20	
	30. Năme and a dures of person who completed cause of death (Item 23a) Pameta E. Southall, MD Assistant Medical Examiner 90		nore, MD 21223	
State Registrar	31. Date filed (Month, Pay 2012 32. Registrar's Signature for the MAR 122012			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Dorothy Mae Willis December 201 1:30 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 3939 Penhurst Avenue 8. Date of Birth (Month, Day, Ye, May 31, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign Days 213-38-9487 Director 1 M 2 X F 72 Maryland Usual Residence of Decedent 10b. County the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? pe 23a Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with must I 3939 Penhurst Avenue 21215 USA ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) custodial maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ပ Glenn Elemore Doyle Pearl Mae Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore City Commission on Aging
10 N. Calvert St #300; Baltimore, MD 21202–1868 Freda Jones - case worker Health a Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🔀 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Signatur of Funeral Service Licen-22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 2101 Part . Enter the disease, or complications that aused the shock or heart failure. List only one cause o death. Do not enter the mode of dying, such as pardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Disease or injury and the burial-trar that initiated events resulting in death) Last Due to (or as ttending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: USe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the la g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The law To the Funeral Director; After this certificate has autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🔲 Yes 2 X Other: ည Nursing Home 5 Residence 6 C Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 🗌 Yes Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 29b. Signature and title of certif 29c License number 29d. Date signed (Month, Day, Year) W. SACT Wo. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 20-22 per f.h. g925 3/16/12 kh

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Baby 50 M 09 19 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baitimore cal Nercy (Y). Social Security Number Medi more Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Months Hours Min. Days Director 0 19 11 2011 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MO timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 1007 Hillman ISA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ko Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: <u>≥</u> Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname R. esha T_{-} VIUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Tiesha Lily 20a. Method of Disposition St 21202 /mother 1007 Hillman Baltimore mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State New Cathedral 12/30/11 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2134 Willow Spring RD. Beth Kehl (per DVR) Bradley-Ashton Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prematurity Physician disease or condition resulting in death) √Medical Due to (or as a consequence of): Examiner Preterm. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical Exam burial-tra Due to (or as a consequence of): Box 68760. IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No Division of Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 3913 eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of mo Kobert 0. Atlas 21202 . Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State me Wag 23 no 3 Per Azio 1 entire Health and Mental Hygiene Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ctober 1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A chost topins Ade (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 2 1 8 – 5 8 – 4 4 6 7 If Under 1 Year If Under 24 Hrs. **Funeral** Hours **Director** 1 🗆 M 2 🔀 F 63 03/08/1948 S.Carolina 28a-f shov 10a State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director ty⊡ Yes 2 ☐ No MDN/A Baltimore 10e. Street and Number 10a, Citizen of What Country? Funeral 1008 Billie Holiday Ct. 21205 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ö þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Companion Private Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rass Bennett Polly Wilson Department of Health and Important: If item 27 is m any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Canty(daughter) 1008 Billie Holiday Ct., Baltimore, MD21205 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Zion Cem. 4 ☐ Donation 5 ☐ Other (Specify) 10/31/11 Baltimore, MD 21. Signature of Funeral Service Licensee 18 Baltimore, I Baltimore, I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) round Medical Due to (or as a consequence of): Examiner TATON APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical the as IF FEMALE ase 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) the Hospital or Attending Physician: The law requires that the death in the past 12 months? for Month Pregnant at time of death Day Year 2 X No the a 9 Unknown 9 Unknowh signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performed this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 💢 Natural 5 Pending 1 🗌 Yes 2 🗌 No eral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral E

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, PhD

\$2. Registrar's Signature

R. Benovives

Day, Year)

APR 0 2 2012

David

31. Date filed (Month

			1 - For Amend Items State Registrar	25 State 84 M	aryland Leeg Cei	tificate of D	Palthain Death		giene Reg. No. 20	11 4362	33
	Physicia	/	1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	th	3. Time of De	eath
	Medi		Vicky Doss					Novembe	er 21, 20	ŎĨ¹1 7:50 .	AMM
	Exami	ner	4a. Facility Name (if not institution, give			4b. City, Town, or		h	4c. County o		
	Funcial		Prince George : 5. Social Security Number 6.		e (In yrs. last birthday)	Chever1	Ly If Under 24 Hrs	8. Date of Birth	Princ	ce George's	
60	Funeral Director			1 □ M 2 🏋 F	55 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Birthplace (State or For Country)	unk
	MC .	١.	Usual Residence of Decedent					Apr 12,	1956		
	ylanc -f sho ed at	Director	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City L	
	e Ma r 28a notifi	Dire	DC 10e, Street and Number		Washin					1 ☐ Yes 2	A No
	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	la l	5000 Nannie Hele	en Burrough	ıs Avenue	10f. Zip Code	20019		10g. Citizen of Wh	nat Country? SA	
	eath v	Funeral	11. Marital Status unk	12. Was Decedent B		Vas Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race	- American Indian.	
9	ter de , or it	þ	1 Never Married 2 Married		No	Vas Decedent of His f Yes, specify Cubar		o Rican, etc.)	Black,	, White, etc.	
21215-0036	urs at tural" al Exa	Completed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🂢 No	Specify:		Specify:	white	
15	72 ho "nat) ble	15. Decedent's (Specify only highest o		(Give I	lent's Usual Occupa kind of work done di		unk rking	16b. Kind of Bus	iness/Industry 1	unk
12	within giene. ner thar t, the M	ပ္ပြ	Elementary/Secondary (0-12) unk	College (1-4 or 5 unk	i+) life. Do	O NOT use retired)					
pd	filed wall Hygad of othe	Be	17. Father's Name (First, Middle, Last,			unk	18. Mother's Na	me (First, Middle, N	Maiden Surname)		unk
/lar	ould be file Id Mental Imarked c matic eve	욘						, , ,	,		
a	and is n		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street a	nd Number or Ru	ıral Route Number,	City or Town, Sta	ite, Zip Code)	
2	and 2 s Health tem 27		Prince George's	Hospital	300	l Hospita	1 Drive	Cheverly	, MD 207	⁷ 85	
ore	ye 1a t of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [☐ Removal from State		sition (Name of natory or other place	e)	Date	20c. Location - C	City or Town, State	
ţim	t. Page tment o rtant: If njury or		4 Donation 5 X Other (Spec	ify) in state							
Bal	permit. Page Department of Important: If any injury or once,		21. Signature of Fineral Service Lie	Dir			-		Baltimo	re Street	
			23a. Part 1. Enter the disease, or con	nolications that caused	the death Do not ente	altimore,	MD 212	01	et	A	
	hysician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	9.			or respiratory arre	st,	Approximate Interval Betwee Onset and Dea	
	Medical		disease or condition resulting in death)	a. ACUTE	a consequence of):	EMBOU	STVI			_	1
1.	Examiner			•	LY OF DEET	PLATIN	THROME	รารเร			
	-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):						
	cuted ind transi	xam	Cause (Disease or injury that initiated events	. HISTOR	LY OF HIP	FRACTU	LE		AF	1	- 0
	ate be executed onlysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	a consequence of):			0 1.1		- EQ	
200	nospinal or Autending Prysician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit	edic	•	d				- In	U INFO	HCAL EXAMINER	
Box 687	eath certificat attending ph for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				· · ·	APPROVED BY MED 23d. Date Month	of dolivon.	
Š.	atter d for u	icia	in the past 12 months?	4 Pregnant at		Ectopic pregnancy Other (specify)	/	CERTIFICATION	Monti	h Day Year	r
о. П	the d by the	hys	9 Unknown	9 Unknown							
P.O.	requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribi	ute to the cause of death	h?
g.	quire; en siç ould b	ted	ALEMIA		_			1 □ Y€	es 2 X No 3	☐ Probably 4 ☐ Unk	known
Records,	has be ye 2 sh	Completed	CHEONIC OBSTI	NOTIVE W	NG DISTAR	E		24a, Was ar autops		ere autopsy findings avail or to completion of caus	
Be	cate he	Col						_ perform	ned? dea	ath? ☐ Yes 2 ☐ No	
Division of Vital	Fnysician: The this certificate are director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1	ce of Death (Che	ck only one)	/		
>	ral dii	2	1 X Yes 2 X A 2 X	1 Inpatie			4 ☐ Nursing F	lome 5 Reside			
ט ט	ding Fn th: After thi funeral	cate	Natural 5 Pending Z XAccident Investigation	(Month, Day,	(Year) injury	28c. Injury work?		28d. Describe ho	w injury occurred Le falls		
isio	al or Attenda s after death. I Director: A id in by the fi	Certificate:	3 Suicide 6 Could not l	De 28e. Place of Injur	ry - At home, farm, stre		100 2 23 110			or Rural Route Number,	-
<u>≥</u>	s after s after all Direction		4 - Homicide determined	building, etc. Unknow				City or Town Unknown	, State)	,	į,
_	io the nospital of Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	rsician: To the best of	y knowledge, death o	ccurred at the time,	date and place,	and due to the cau	se(s) and manner	as stated. the cause(s) and manner	
-	within 24	Me	only one) 3 L Certifying Nu	se Practitioner: To the	best of my knowledge,	death occurred at the	e time, date and p	at the time, date and lace, and due to the	e cause(s) and mar	ner as stated.	er stated.
·	5 5 Wit		29b. Signature and title of certifier	1 910.	· · · · · · · · · · · · · · · · · · ·	29c. License		29	9d. Date signed (I	Month, Day, Year)	
			Luguenett	1 NOW	V "		1435		11/22/11		
			30. Name and address of person who	completed cause of de	eath (tein 23a) (Type, Pr		HATT G	27 (17)	nd 1	ANHAM, MD 2	0701
	Stat	e_		32. Registrar	r's Signature		THE P	عار مارد	10-1 L4	לאין ווייוואסמי	210,0
	Registra	r	31. Date filed (Month, Day, Year) APR 0 2 2012	Much	A back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPt1,11 25 per me, 2925,03/21/2012dhb

Certificate of Death

Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4200 P Vorman ngust o' 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harbor Hospita Baltimore N/A Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**M**M 2 □ F 0872771962 Maryland 214-90-6609 **Director** 48 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2209 N. Dukeland St. 21216 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. ō 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify: "natura!" Specify: Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than 9th Grade College (1-4 or 5+) Handy man Emanuel Jackson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file Health and Mental ျှ Norman Johnson Sr. Beatrice Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Johnson Sr. (Father) 2209 N. Dukeland St., Baltimore, MD 21216 or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If ite any injury or of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 08/10/11 Baltimore, MD 21. Signature of Funeral Service Licenses 305ephodrsofFBrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) (or as a consequence of) Complications of Encephalopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a coris Cerebrovascular Accident signed by the attending physician and dbe detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last MINER Hypertension and Cocaine Use Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ L 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> stage End Division of Vital Records, rena Completed 1 Yes 2 No 3 Probably 4 Unknown peen s . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed hronic respirator Hospital or Attending Physician: filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation ⊥ Accider □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 within 2 To the 1 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier υb 205 00 who completed cause of death (Item 23a) (Type, Print) 30. Name and

State

Registrar

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2. Registrar's Sigr

Hanover

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROBERT Month WIEGEL **Physician** 2012 PM NOVEMBER 23,2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** 1**※** M 2 □ F Months Days Hours Min 213-34-8409 74 March 8,1937 Director Maryland Usual Residence of Decedent he filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ust be notified at Director Md. N/A 1 ¥ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? must be 1418 Bonsal Street 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify Specify: White ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) Balto. County School Personal Asst. 11 years 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, Be Joseph Edward Wiegel Genevieve A. Brandt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Wiegel Wife 1418 Bonsal Street, Balto. Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 28, 2011 21. Signature of Furgeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Mar M01176 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 28a. Part 1. Approximate Interval Between Onset and Death shook, or heart failure. List only one cause on each line. Immediate Cause (Final intracrania **Physician** HR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, iding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗌 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 2 Accident 1 Yes 2 No filled in by the Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Elpert

APR 0 2 2012

31. Date filed (Month, Day, Year)

RE(-000

4940 Eastern Avenue, Baltimore, MD, 21224

			1 - State Amend Item Registrar	State of Ma s 23a,25,27	arylan , 28 2	id / Depa a-f pe i	artmen tificate	t of F 926 07 L	lealth 04/0 Death	and Mental H 5/2012dhb	ygiene Reg. No	2011-	43636
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Stable	Medic Examir		James C. Borgma 4a. Facility Name (if not institution, giv				4b. City.	Town, or	Location of	Nove		26 20 County of Deat	
-		П	Sinai Hospital a	& Baltimo			BaH	imo	re Ca	ity			
	Funeral Director		5. Social Security Number 6. 8	Sex 7. Age IXIM 2 □ F	(In yrs. k	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8. Date of I	Birth Da <i>y</i> , Year)		hplace (State or Foreign untry)
			Usual Residence of Decedent 10a, State 10b, County		50	Yrs.				Apr 28	, 196	1 Mar	yland
	arylan ia-f sh ifled a	Funeral Director	MD Tob. County	}	Tuc. City	y, Town or Loc Balti							10d. Inside City Limits 1X☐ Yes 2 ☐ No
	the M or 28 oe not	٦	10e, Street and Number			Dalti	10f. Zip	Code			10g. Cit	izen of What Co	
Ž	th with ns 23e must t	nera	2525 W. Belvede						2121			USA	
olton	or iter	by Fu	11. Marital Status1 X Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 1	er in U.S	S. 13. V	Vas Decede Yes, speci	ent of His fy Cubar	spanic Oriç n, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	D-	14. Race - Ame Black, White	
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212	within giene. ler tha		Elementary/Secondary (0-12)	College (1-4 or 5+	-)	me. Do	plum				hom	e impro	vements
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ZŽ	nd 2 steatth a m 27 is m 27 is ner tra		Linda Wengert/si	ster		6411	Rock	1edg	ge Co	urt Elkrid	ge, M	D 2107	
Sorgmann, Jaw Baltimbre, Maryland	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Speci			lace of Dispos emetery, crem			e)	Date	20c. Lo	cation - City or	Town, State
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Division of Vital Records, P.O. Box 687	the Hospital or Attending Physician; The law requires that the death certificathin 24 hours after death. The Funeral Director. After this certificate has been signed by the attending phypletely filled in by the funeral director, page 2 should be detached for use as the property of the funeral director, page 2.		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal	Ideath 3	Ectopic pr Other (spe				2	23d. Date of deli Month	very Day Year
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of	ng Phy fter thi	ate: T	27. Manner of Death 1.22 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	1	ER/Outpatient 28b. Time of injury	-	c. Injury a work?	_ 4 ∟ Nur at	sing Home 5 Res	how injury	occurred	
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4	To the Hosp within 24 hor. To the Funer completely fi	Med	(Check 2 Medical Exami	sician: To the best of moner: On the basis of example Practitioner: To the basis	mination	and/or investig	ation in m	/ opinion	death occ	jurged at the time date	and place	and due to the co	ause(s) and manner stated
T	 함 은 형	1	29b, Signature and title of certifier		١			icense r				signed (Month,	Day, Year)
	1	4	80. Name and address of person who d	empleted cause of dea	MI th (Item 2		- 1	E80	000_		1120	82011	
			Ily Kristine F. 11. Date filed (Month, Day, Year)	YUMBI S	indi	Hospi	tal o	B	altimo	ore			
	State Registra	~	APR 0 5 2012	32. Registrar's	Signatu 7.	parke	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a, Ptlb, 25, 27 per me 2926, 04/16/2012dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ YIIN1 Month 70,201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death B ALTIMORX NAIHOS PITM If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Jumaica 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 X F Hours (Month, Day Months Yrs Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 □ No Over/Minto-Scelmen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA engule 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event than the statement of the s Elementary/Seconday (0-12) College (1-4 or 5+) Private CNA 2+12 arade Year Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Samuel Hamilton Munroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leafredate Court Paulette tteron Kaltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Yuid Ridge Cemeten(1 XBurial 2 Cremation 3 Removal from State 03/31 4 Donation 5 Other (Specify) Druid 21. Signature of Funeral Service License 22. e and Address of Ficility laughrz GUECKEPUNGRAP SENICES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate terval Between nset and Death Immediate Cause (Final Physician/ Brown 4noxic disease or condition days Medical resulting in death) Due to (or as a consequence of): Examiner Cardiac Arrhythmia during Esophagogastroduodenoscopy Securitally let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Attending Physician; The law requires that the death certificate be executed for use as the burial-transit that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending injury 2 Accident 3 Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the second of the seco (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-OUL eli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Short Hospital

A. Anim Livena M. 2461 W. Believele Ane. OL Bar (France Bultman use 2. Registrar's Si Alture State Registrar

			For State	State of Maryland			Mental Hygie	ene 2011	1121 20
			Registrar 1. Decedent's Name (First, Middle, La	est)	Certificate of	Death	2. Date of Death	1. No. 2011	75650
	Physici Medi		LOWRENCE	White			OCTOBER	^{Day} 9,2011	³ Time of Death 2 : 31 P _M
-	Exami	ner	4a. Facility Name (if not institution, given SAINT JOSEPH M			or Location of Death ${ m ON}$	1	4c. County of Deat BALTIMO	n RE
	Funeral Director		5. Social Security Number 6. S 033-14-3558 Usual Residence of Decedent	Sex 7. Age (In yrs. last.	birthday) If Under 1 Year Months Days Yrs.		8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign untry)
	land show d at	호	10a. State 10b. County		own or Location] W/V K		10d. Inside City Limits
	e Mary r 28a-t notifie	Jirec	MD.	Bal	T- City				1 Yes 2 □ No
	with th	Funeral Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
	death items ner mu		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
9000	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at,	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 Tes 2 No		o nican, etc.)	Black, White	e, etc.
15-(72 hou n "natu ledica	nplet	15. Decedent's E (Specify only highest gr		6a. Decedent's Usual Occu (Give kind of work done	during most of work	king 16	b. Kind of Business/	
212	within giene. er thal		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired			UNK	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Maid	den Sumame)	
, Mar	id 2 should salth and Me		19a. Informant's Name/Relationship (7	Type, Print)	9b. Mailing Address (Street	and Number or Rur	^	ty or Town, State, Zip	*
Baltimore,	Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State 20b. Place	e of Disposition (Name of etery, crematory or other pla	ce)	Date 20	c. Location - City or	Town, State
Baltin	permit. Pag Department Important: any injury c		21. Signature of Fine al Service Licen:	5 18.01	22. Name and Addre	ess of Facility	20-11 B		
			23a. Part 1. Enter the disease, or con-	plications that caused the death. D	2829 HU	ng, such as cardiac	or respiratory arrest.	10 212	Approximate
	Ph_sici_n Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ANOXIC ENC	EPHALOPATH:				Interval Between Onset and Death
	Examiner	16	Sequentially list conditions.	Due to (or as a consequence CARDIAC ARR					
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	CORONARY AR		SE			
	cate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last	C. Due to (or as a consequence	e of);				
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Box 68760	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de: 4 Pregnant at time of death	ath 3 Ectopic pregnand	су		23d. Date of del	very Day Year
о В	the de by the tached	hysi	1 Yes 2 No 9 Unknown	g 🗌 Unknown					
ds, P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	<u>ا</u> ۾	Part II. Other significant conditions of	ontributing to death but not resultin	g in the underlying cause gi	ven in Part I.		co use contribute to	the cause of death?
Records,	law rec has bee e 2 shc	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u> </u>	sician: The law is certificate has the law intector, page 2 s		25. Was case referred to medical		00.00		1 Ves 2	i? death? No 1 ☐ Yes	2 🗆 No
Vita	hysicia nis cert I direct	To Be	examiner?	Hospital: 1 X Inpatient 2 ☐ ER/0	Oth	er: 4 Nursing Ho	<i>k only one)</i> ome 5 ☐ Residence	e 6 ☐ Other (Speci	fv)
n of	ding Pl h. After th funera	ate:	27. Manner of Death 1 Natural 5 □ Pending	(Month, Day, Year)	. Time of 28c. Injur injury work	y at k?	28d. Describe how is		
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			Yes 2 No	28f. Location (Street		al Route Number,
ă	pital o		002 0245				City or Town, St	,	
	ne Hos n 24 hc ne Fun pletely	Medical	(Check Z L) Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and se Practitioner: To the best of my kn	or investigation in my opinion	on death occurred at	t the time date and nl	are and due to the c	auco(c) and manner stated
	No the control of the	— г	29b. Signature and title of certifier	L.MD	29c. License	e number		Date signed (Month	
			30. Name and address of person who c	omploted gauge of death (the see	D240	<u></u>		0/19/21	2(1
1	V		TIMOTHY LOW, M.			SON, MD 2	1204	,	
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 6 2	32. egistrar's Signature	parke				

White, Lawrence

Trieu Tram Trar	ı	1- For State	tate of Marylar		artment of		and Me	ntal Hy	-	eg. No. 2011	4210	29
Physici Medical Exam		1. Decedent's Name (First, Mid							2. Date of Deat	h	3. Time of	
wedicai Exami	ner	Trieu Tram '		ber)		b. City, Town,	or Location	n of Death	Month Septembe	r 6, 2011 4c. County of	21121	nrs
,		Park & Ride Long Ga				Ellicott Ci				Howard		
Funeral Director		5. Social Security Number 216-37-9741	6. Sex 7		last birthday)	If Under 1 Y	ear If Un ays Hou	der 24Hrs.		190	9. Birthplace (State Foreign	
		Usual Residence of Decedent	11 <u>A</u> M 2 F	39	Yrs				10//13	3/1973	CountrWie	tnam
ow any		10a. State 10b. County			, Town or Locati	on						City Limits
aryland Sa-f she	Director	MD Anne 10e. Street and Number	Arundel	S	evern	10f. Zip Code	-		110	ng. Citizen of Wha		2 [X] NO
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f show injury or other traumatic eveot, the Medical Examiner must be positified at once.		7847 Manet	Way			211				USA	, , , , , ,	
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fter dez 17, or i	щ		1 Yes	2 X No		Yes 2 X				Specify:	Asian	
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136 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		Maker		T doc roun		Box	Making	
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2121 Ild be fi Mental narked eveot,	To Be	Diep Tran 19a. Informant's Name/Relations	shin (Tyne Print)		10h Mailing	Addross (C)			Truong	ber, City or Town,	Olate Tie Onde)	
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other transmitic evect, the Medical			cother		1.0	•				cel MD		
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Bal permi Depar Impo	1	21. Signature of Funeral Service	Licensee		722. N	omas Al	ess of Facil	^{ity} Sim	plicit 190 Ric	y Crem	& Fun Hanover	Serv
Physician //Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that cause on each line.	sed the death	. Do not enter th	e mode of dyir	ng, such as	cardiac or	respiratory arre	st, shock, or hear	t Approxima	ate Interval Onset and
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ox 68760, sath certificate be executed attending physician and for use as the burial - transition.	dical	UNPENDED	d AMENDED									-
Certificate by nding physic as the bur		IF FEMALE: 3b. Was decedent pregnant in t	23c. If yes, out			-				23d. Date of de		
x 68 th certif	iciar	past 12 months?	4 Pregnan	i at time of de	ath -	al death S er (S <i>pecify</i>)	BEctop	oic pregnar	icy	Month	Day	Year
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n of Vid ding Physic After this funeral dire	٩	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	njury	ER/Outpatient 28b. Time of In		jury at Wor	k? 2	28d. Describe ho	Residence 6 🗸		
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Division pital or Attendi ours after death.	Certification:	dete	a not be	Injury - At he Parking Lo	ome, farm, street	, factory, office	building, e		or Town, Sta	ate)	or Rural Route Nu	
		4 Homicide 29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowled	ge, death occurre	ed at the time,	date and p	lace, and c	lue to the cause	(s) and manner a	s stated.	, Eliicott Ci
Division To the Hospital or Attentiful or Attentiful or Attentiful or the Rooeral Director: completely filled in by the fi		one) 2 Medical Exa	miner: On the basis of e and manner state	xamination a	nd/or investigation	on, in my opinio	on, death o	ccurred at	the time, date a	nd place, and due	to the cause(s)	
	2	29b. Signature and title of certifie	will and				nse numbei C.M.E.	r		29d. Date signed September 7	(Month, Day, Year '. 2011)
		Hunuld Vuith 30. Name and address of person	who completed cause of	of death (Item	23a)						,	
51		Pamela E. Southall, M				W. Baltimo	re Stree	t, Baltim	ore, MD 21	223		
Sta Registi		31. Date filed (Month, Day, Year) MAY 2 9 201	2 August	trar's algnatu	pare							

Robin Kathleen A		1- For State	State	of Maryla			nt of He te of De		nd Ment	al Hyg		201	١.	421410
Physiciar		Registrar 1. Decedent's Name (First,	Middle,La	st)		rtmoat	.0 01 20	, attr		2.	Date of Dea	eg. No. 201		3. Time of Death
Medical Examin	er	Robin Kath									Month July 15, 2	Day Year		1150 hrs
)		4a. Facility Name (if not ins		ve street and nu	ımber)		1		r Location of	Death		4c. County o		
,,	4	1309 New Coach						wie				Prince G	_	
Funeral Director	1	5. Social Security Number	6. S		7. Age (In yrs.	last birthd		Jnder 1 Year onths Day				rth(MM/DD/YYYY)	9. BirtlForeign) ~~~
Director	ļ	353-48-3165		м 2 X F	57		Yrs.		7.104.10	1,,,,,,,	Aug. 1	.4, 1953	Cou	intry) 1L
any .		Usual Residence of Deced 10a. State 10b. Co			10c. City	y, Town or	Location							10d. Inside City Limits
		MD Pr	ince	George'	1 -	,		Bo	owie					1XX Yes 2 No
arylan	Ulrector	10e. Street and Number		000160	0		10f.	Zip Code			1	0g. Citizen of Wha	at Coun	
the M	<u> </u>	3109 New	Coach	Lane					2071	.6		-	.s.	•
with ms 23.	uneral	11. Marital Status			edent Ever in U	J.S. 1			spanic Origi			14. Race -	Americ	an Indian, Black,
death or ite	5	1 Never Married 2	Married	Armed Fo	orces?		If Yes, sp	ecify Cubar	n, Mexican, I	Puerto Ric	an, etc.)	White,	etc.	
after or ral", or iner m	<u>-</u>	_		If Yes, Give Year or Dates:	r			2 X No			_	Specify:	Wh	ite
hours Exam	<u> </u>	15. Decedent's Education Elementary/Secondary (16a. De dur	cedent's Us ring most of	ual Occupa working life	tion (Give ki	nd of work	done	16b. Kind of Bus	iness/In	dustry
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215 be file ntal H rked o		Charles Kab	e1ka								Zygmu	•		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Rela	ationship (T	ype, Print)					et and Numb	er or Rura	I Route Num	nber, City or Town	State,	Zip Code)
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s lar of Hea of Hea	1	20a. Method of Disposition 1 Burial 2 XX Cren	nation 3	Removal fro	20b.	Place of D crematory	isposition (I or other pla	Name of cer ice)			ate	20c. Location - 0	City or T	own, State
Page Page ment o		4 Donation 5 Oth	er Specify		Me	Λ\	Cremai	•			-2012	Baltim		, MD
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be executed isitian and urial - transicial Ex	3	UNPENDED		AMENDED										
760 ficate g phys	. —	F FEMALE: 3b. Was decedent pregnan	t in the		outcome of preg	nancy						23d. Date of de	elivery	
Box 6876(: death certificate the attending phy. d for use as the brands.	5	past 12 months?		1 Live bit	rth ant at time of de	2 _ eath 5	Fetal dea		Ectopic p	regnancy		Month	Da	y Year
). Box 6876; the death certificate by the attending phy cheed for use as the Physician/M.	2	1 Yes 2 No 9	Unknown	9 Unknow	wn	3	Other (S	респу)						
		Part II. Other significant co	onditions	contributing to	death but not r	esulting in	the underly	ing cause g	iven in Part	l.	23e. Did to	bacco use contribu	ite to th	e cause of death?
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ion of tending Pheeath. the funeral the funeral attion: T		7. Manner of Death 1 Natural 5		28a. Date o (Month, I	of Injury Day,Year)	28b. Time	e of Injury		y at Work?		Describe h	ow injury occurred		
Sion Attender death cector:			Pending Investigatio						es 2 N					
Division of spital or Attending tours after death. neral Director: Aft filled in by the function:			Could not be determined	e I	of Injury - At he	ome, farm,	street, facto	ory, office bu	uilding, etc.	28f.	Location (S or Town, St		or Rura	Route Number, City
Tospit Tospit Tunerally fill		Homicide	-	(0,000))	of my knowledge			da - 41 4		237/2				
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	0			On the basis of	examination a							e(s) and manner as and place, and due		
Z S H S E	2	9b. Signature and title of ce	ertifier	and manner sta	ated.		2	29c. License	number			29d, Date signed	(Month	n, Day, Year)
		11			100		1	O.C.N	Л.E.			July 16, 2011	I	
1.17	8	Name and address of pe		460	,	,								
Atl	4	Russell Alexander		Assistant Me			00 W. Ba	altimore :	Street, B	altimore	, MD 212	23		
State Registra		1. Date filed (Month, Day, Young)	302	32. Reg	strar's Signatu	ire	have	J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hydiane / 23aPt 1,11,25,27,28a-1 per me, g928,06/11/2012dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month. 903 ORROBAI 10 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death BANKFOAD NOG tIMORE Security Number 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Mar 30, If Under 24 Hrs **Funeral** . Age (In yrs. last birthday) ▼ M 2 □ F Months **Director** 220-72-9867 Yrs. 1976 35 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21212 5528 Midwood Road items ? within 72 hours after death n "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married Black, White, etc. þ Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: black Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education UTIK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk unk t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot ijury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frankford Nursing & Rehab Ctr 5009 Frankford Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department o Important: If any injury or 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) in state 4 Donation permit. Sign to ²² Name and Address of Facilit Board 655 W. Baltimore Street Director MD 23a. Part Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Adult Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Gunshot Wound to Head Sequentially list conditions. ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): JICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last NON APPROVED BY signed by the attending physician and Due to (or as a consequence of): Physician/Medical CERTIFICA Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dysphagia Cerebral Palsy 1 Yes 2 No 3 Probably 4 Unknown Completed should peen Malnutrition, Falls Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Paraplegia, Self-Extubation 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Certificate: To 2 100 Other: within 24 hours after deau..

To the Funeral Director: After this of the funeral director of the funeral director. 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? [5 Pending Unknown Unknown Unknown **Unknown**^M Accident Investigation 6 X Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Unknown Unknown Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 23a) (Type, Print) P 8813 ham Woods Rd H204 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct ľľ 2**01**1 7:25 PM Kathleen Barron Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Forest Haven Nursing Home If Under 1 Year If Under 24 Hrs.

Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral Director** 218-44-8017 1 M 2 X F 66 Yrs MD 1/21/1944 Usual Residence of Dece 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director MD Baltimore Catonsville 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Б 10e. Street and Number Funeral 23a 21228 USA 701 Edmondson Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceus... Armed Forces? ¹ ☐ Yes 2X No 11. Marital Status Examiner Black, White, etc. ō þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown unk. traumatic event, Be unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked ည 19b Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 611 Central Ave., Towson MD 21204 and l 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traunonce. MD Dept. of Aging 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/21/11 Baltimore, MD 4 Donation 5 Other (Specify) Carme1 22. Name and Address of Facility 21. Signature of Funeral Service Licenses THOMAS J. SKARDA, PER DVR Skarda Funeral Home, 3829 Hudson St., Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Urinary Tract Infection Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Atherosclerotic Cardiovascular Disease death certificate be executed Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for 5 Other (specify) Pregnant at time of death 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 After this certificate has 1 Yes 2 No director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) ပု 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural work? 5 Pending 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After filled in by the within 24 hor To the Fune completely fi

moten 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolphin St., 501 Baltimore, MD 21217

Amatum Naeem, 31. Date filed (Month, Day, Year)

3

29b. Signature and title of certifier

istrar's Signature AUG 08

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D15503

29d. Date signed (Month, Day, Year)

OCTOBER 12 2011

State

Registrar

Medical

29a. Certifier

(Check

	AMEND #:	25,	27,28A-F,PER ME	"G929"7/1671	In In Plack I	indelible ink	C. Ensure	All Copie	s Are Leg	gible.
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	Physicia Medi		Clarence Jos	nes Jr.				Novem.	21, 2	Year ans
-	Exami		4a. Facility Name (if not institution	/	1-0	4b. City, Town, or	Location of Death	1	4c. County	
	Funeral		Makyland Gre 5. Social Security Number	NETAL HOSE 6. Sex 7. Ac	ge (In yrs. last birthday)	Buctim If Under 1 Year	If Under 24 Hrs	8. Date of Bi	N/A	Birthplace (State or Foreign
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	land show dat	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	er death with the Maryland or items 23a or 28a-f sho miner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
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(0		by Fu	11. Marital Status 1 Never Married 2 □ Mar	12. Was Decedent Armed Forces?	' I	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		ce - American Indian, ck, White, etc.
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C/ mo	Page 1 nent of ant: If it		1 Burial 2 Cremation 4 Donation 5 Other (S	3 ☐ Removal from State	cemetery, cre	matory or other place Cremato) / .	30/11		
Clane. Maryland	permit. Page 1 Department of Important: If i any injury or of		21. Signature of Funeral Service L	icensee						Home PA
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	<u> </u>		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	complications that caused only one cause on each line	d the death. Do not ent e.	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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68760	eath certificate to attending physi I for use as the b	Physician/Med	IF FEMALE:							
Box 6	ath cer attendi for use	sian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy			23d. Dat	te of delivery nth Day Year
B	es that the dex signed by the a I be detached i	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	it time of death 5 L	Other (specify)			100	nui Day rear
P.O.	s that t gned b		Part II. Other significant condition			ınderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
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of of	ing Ph (fter th uneral		27. Manner of Death	28a. Date of injur	ry 28b. Time of		at		ow injury occurre	
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23 p	al or A s after Il Direct	<u>ē</u>	4 Homicide determi	building, etc	ury - At home, farm, stre c. <i>(Specify)</i>	еет, тастогу, опісе	Į.	28f. Location (S City or Tow BALT IM(r or Rural Route Number S • CAREY ST
#	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of	my knowledge, death o	occured at the time, d	date and place, an	id due to the car	rea(s) and manne	er as stated. to the cause(s) and manner stated.
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W	F S F O		▶ Amande	up Singh	M.D.	29C. License n	1087		29d. Date signed	(Month, Day, Year)
			30. Name and address of person w	/ho completed cause of de	eath (Item 23a) (Type, P	rint)) 1	./	100	1
			HMOVALLE ST B1. Date filed (Month, Pay, Year)	igh, M.D	. 90 Mar	ylana G	reneral	HOSPIT	al_	
	State Registra	-	NFC 0 1	2011 32. 5 stra	r's Signature	a del				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 12 28 2011 Year 18:43 Madeline Perdue Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Wicomico Salisbury 1307 Frederick Ave. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Davs Hours Min. 214-34-5236 Director 1 XM 2 F Yrs 91 MD 4 6 1920 Usual Residence of Deced 28a-f show 10d. Inside City Limits 10c. City, Town or Location äţ 10a. State 10b. County Director notified 1 X Yes 2 No Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be r Funeral USA 21801 1307 Frederick Ave. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Examiner Armed Forces? ö 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White er than "natural", the Medical Exal 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Corporate Secretary Poultry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Mae Dickerson George Elmer Bower Godfrey permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 766 Salisbury, MD, 21803 Jim Perdue Son 3altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 1 2 2012 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Holloway Funeral HOme P.A. 501 Snow Hill Rd., Salisbury, MD, 21804 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of shock, or heart failure. List only one cause / n each line. dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Deatl Immediate Cause (Final Physician/ 5 years disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the at Id be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 Yes 2 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
	State of Maryland / Department of Health and Mental Hygiene									
			Registrar 1. Decedent's Name (First, Middle, Last)	Certif	ficate of Death	Reg. N 2. Date of Death	0.	75676		
F	Physicia Medio		Sophia	Jade Molitor		Month D	Year 201	3. Time of Death		
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	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M	f Under 1 Year If Under 24 Hrs. lonths Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Bir	thplace (State or Foreign puptry)		
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Saltimore Dermit. Page 1 ar	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Creptation 3 ☐ Re	20b. Place of Disposition cernetery, cremator		ate 20c.	Location - City or	Town, State		
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De law r	e has b age 2 st	Completed				24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of		
ien: T	nis certificate has I director, page 2	Be C	25. Was case referred to medical examiner?		26. Place of Death (Check	1 Yes 2 1 n	lo 1 ☐ Yes	s 2 🗆 No		
Physic	this ce	၉	1 Yes 2 No Hos	1 ☑ Inpatient 2 ☐ ER/Outpatient 3		e 5 Residence	6 ☐ Other (Spec	ify)		
ath.	r: After	icate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No			. Describe how injury occurred			
el or Atte	Director d in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	- At home, farm, street, factory, office 28f. Location			(Street and Number or Rural Route Number, wn, State)		
B Hospite 124 hours	e Funera letely fille	Medical	(Check 2 L. Medical Examiner:	n: To the best of my knowledge, death occu On the basis of examination and/or investigati	ion, in my opinion, death occurred at t	he time date and place	e and due to the	rause/s) and manner stated		
To the within	To the	2	29b. Signature and title of certifier	actitioner: To the best of my knowledge, dea	29c. License number		e(s) and manner a ate signed (Monti			
,,			- the	nW.	270714		5/91	2013		
K.	*		Haytham Hamw.	leted cause of death (Item 23a) (Type, Print)			1921.			
F	State	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1					

⁄ulia Pogrebenko	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death	42147
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death
Medical Examiner	Yulia Pogrebenko 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De	1158 hrs
	Sandy Point State Park Annapolis Anne Arund	
Funeral Director		Birthplace (State or UNK eign Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Russia	1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	16 Lapina St #5	Suntry ?
hours after death with the Maryland batural", or items 23a or 28a-f sh Examiner must be potified at once ied by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? unk 1 Yes 2 No	
urs afte	3 Widowed 4 Divorced II Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: 15 Decedant Function (See Vision of See Visio	vhite
6 5 2	Elementary/Secondary (0-12) College (1-4 or 5+) unk during most of working life. DO NOT use retired)	
		mk.
2121 could be fill d Mental I s marked fie event, I		ate, Zip Code)
MD nd 2 sho alth and m 27 is	0.C.M.E. 900 W. Baltimore St; Baltimore, MD 2	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury ar other traumatie or	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 1n state 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City	or Town, State
Ball permit Depart Impor	21. Significantly State Anatomy Board 22. Name end Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MI	21201
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
/Medical ≟xaminer	Immediate Cause (Final disease or condition resulting in death) a. No Anatomic or Toxicologic Cause of Death Due to (or as a consequence of):	Death
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
ted Insit	couse. Enter Underlying Couse (Disease or injury that initiated	
e executed cian and urial - trans	UNPENDED AMENDED	
	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delive the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (Specify) Other (Specify)	ery Day Year
D. B. It the de ached f		to the cause of death?
s, P.O. ires that the signed by 1 be detach	1 Yes 2 No 3 P	obably 4 Unknown
Division of Vital Records, ral or Attending Physician: The law requirer as after death. Al Director. After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓	
ician: certifi rector.	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
of Viger this neral di	27 Manager of Double 1999 Date of January 200 Time of January 200 Date of January 200	er: Scene
ion teath. tor: A the furthe furth	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Subject found floating in bay half	after being cut in
Division of Vital Reconting Physician: The Workin 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page edical Certification: To Be Con	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) (Specify) Unknown 28f. Location (Street and Number or I or Town, State) Sandy Point State Park/Mid-Char	
To the Ho within 24 Pu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	
	29b. Signature and title of certifier 29d. Date signed (No. C.M.E. 29d. Da	onth, Day, Year)
	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	
State Registrar		
l regional	JUNE DEUTO LEGICA DE MARCO	

				State of M	T per larylan					d Mental H				m 11 m	
			State Registrar			Cer	tifica	te of L	Death			<u>. 201</u>		3648	
	Physicia Medic		1. Decedent's Name (First, Midd Florinea King	Ige						2. Date of I Month Oct	Death Da		ar	Time of Death 9:30 P M	
, -	Examin	er	4a. Facility Name (if not institutio				4b. Ci		Location of Deurel	ath		County of E		ra¹s	
ممسيد	Funeral		Laurel Region 5. Social Security Number		je (In yrs. la	ast birthday)		der 1 Year	If Under 24 H		Birth		Birthplace	(State or Foreign	
ů.	Director		578-78-4287 Usual Residence of Decedent	1 □ M 2 🖫 F	54	Yrs.	Month	s Days	Hours M	(manning a	Day, Ye <i>ar)</i> /1956	5	Country) DC		
	yland f sho	tor	10a. State 10b. County	/	10c. Cit	y, Town or Lo								nside City Limits	
	e Mar 28a- notifie	Director		gomery		Germa					1			1 X Yes 2 No	
	should be filed within 72 hours after death with the Maryland of and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show aramatic event, the Medical Examiner must be notified at	ral	10e. Street and Number	Doint Dlago			101. 2	Zip Code	876			itizen of Wha JSA	t Country?		
	ems ?	Funeral	11446 Stoney	12. Was Decedent		S. 13. V	Nas Dec	edent of H	ispanic Origin?	(Specify Yes or N	_	14. Race - A	American In	idian,	
92	fter de , or it	by F	1 Never Married 2 Ma	Armed Forces? 1 Yes 2 If Yes, Give	X ^{No}				in, Mexican, Pu	erto Rican, etc.)		0 11	Vhite, etc.		
21215-0036	tural"	Completed	3 Widowed 4 Divorce	d Year or Dates.					Specify:		\perp		Afr.		
15-	72 ho n "na Aedio	nple	(Specify only high	ent's Education lest grade completed)			kind of v	sual Occup vork done o use retired)	ation during most of v	vorking	16b. ł	Kind of Busine	ess/Industr	У	
212	within giene.	ပ်	Elementary/Secondary (0-12)	College (1-4 or 9	5+)				es Coor			Priva	te		
bu	filed val Hyg	Be c	17. Father's Name (First, Middle,	Last)		Mar James		6-3 Y	18. Mother's N	lame (First, Midd					
yla	Ild be Ment narke	ပ္	Abraham King							othy Lee					
Maryland	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relation			1				Rural Route Num)	
d)	and 2 Healt tem 2		Frenise Crawf 20a. Method of Disposition	ord/daugnter		l 20 Place of Dispo			snoe be	nd Cir.,		ocation - City		State	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		, _ c	emetery, cren	natory o	r other plac		/2/11		andove			
altir	mit. P partme sortar injur		21. Signature of Funeral Service		Ha	ermony 22	2. Name	and Addres	ss of Facility	Stewart					
Ä	De any		John T. Stew	art per DVR		4	1001	Benn	ing Roa	d, NE Wa					
	Ph _y sici∠n , Medical		23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each lin	_{e.} rovas	cular			g, such as card	ac or respiratory	arrest,		Inte	proximate erval Between set and Death	
Some	Examiner	<u>.</u>	Sequentially list conditions,	bMetas	tatio	Cance	r								
	executed an and irial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as											
0	project be	g	resulting in death) Last	Due to (or as	a consequ	uence of):									
376	ficate g phys as the	/ledi													
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the long physician.	Completed by Physician/I	by Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					Ectopic pregnancy Other (specify)			-	23d. Date of delivery Month Day Year		Year
s, P.O.	requires that the dea been signed by the a should be detached			by	Part II. Other significant condit	ions contributing to death b	but not res	ulting in the u	ınderlyin	g cause giv	ven in Part I.				
cord	law requ has beer ge 2 shou										topsy	24b. Were prior deat	to comple	indings available tion of cause of	
æ	: The icate ! r, pag									_1 □ Ye	rformed? s 2 🖂		Yes 2	No No	
lta	siciar certif lirecto	m	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:				Oth	ace of Death (C			- 🗆			
of \	g Phy er this reral d	e: To	27. Manner of Death	28a. Date of inju	ury	ER/Outpatier 28b. Time of		28c. Injur	y at	g Home 5 Re 28d. Describ			pecity)		
U O	ending seth. or Afte	ficat		tigation	iy, Year)	injury	М	work	(? Yes 2 □ No						
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director After this certificate he completely filled in by th afuneral director, page	al Certificate:	3	28e. Place of Inj building, et			eet, fact	ory, office			(Street ar own, State	nd Number or 9)	r Rural Rou	te Number,	
	e Hosp n 24 hou e Funer	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e	examination	n and/or invest	tigation,	in my opinio	on, death occurr	ed at the time, dat	e and place	e, and due to	the cause(s		
	Nothing the state of the state	2	29b. Signature and title of certific		TO DOG! CT!	Ty Thomas Og		9c. License		or jorder - de l'order 1	1	ate signed (M			
			Ma Ma	M-19				D672	210		7	11713			
			30. Name and ad ss of persor Dr. Rohit Khi	who completed cause of c	death (Item	1 23a) (Type, F	Print)	1250	Rorbe	The mir	2 7	087V			
	Sta	te	Dr. Rohit Khi 31. Date filed (Month Ge)	1 2013 32 Jegistr	ar's Signal	ture	1		, ,		_		-		
	Registra	ar		Lines	M	B. B	ave.								

DHMH 17 Rev 06-2011

			amend #	26 Per PHY (State of Mar				Mental Hy	giene	101.50					
	•		Registrar 1. Decedent's Name (First, Middle, La	et)	Cei	tificate of	Death		Reg. No.	73000					
. *	Physician/ Medica		Shirley Mad			2. Date of Dea Month	14. 2011	3. Time of Death							
	Examir	ner	4a. Facility Name (if not institution, give 7405 Beech Ave			4b. City, Town, Ba]	or Location of Deat Ltimore	า	4c. County of Dear	th					
4000	Funeral		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year		8. Date of Birt	h 9. Bir	thplace (State or Foreign					
	Director		Unk. Usual Residence of Decedent 1 M 2 F 73 Yrs. Months Days Hours Min. (Month, Day, Year)							N/A					
	Maryland 28a-f sho	Funeral Director	Maryland N/A	1	Oc. City, Town or Lo Baltimo					10d. Inside City Limits 1 √ Yes 2 □ No					
	with the s 23a or ust be n	eral D	10e. Street and Number 831 N. Gilmor S	treet		10f. Zip Code 21	217		10g. Citizen of What Co USA	ountry?					
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show with jujury or other traumatic event, the Medical Eventhar must be natified at once.	ed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, GiveX Year or Dates.	, '	Was Decedent of f Yes, specify Cub	Hispanic Drigin? (Sp pan, Mexican, Puert o <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit SpecifyBla	e, etc.					
Maryland 21215-0036	vithin 72 hou liene. ir than "natu the Medical	Be Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th grade	ducation ade completed) College (1-4 or 5+)	(Give i	dent's Usual Occu kind of work done O NOT use retired Ceria W	during most of wor f)		16b. Kind of Business. Morgan St	ate					
yland 2	ild be filed v Mental Hyg iarked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Shirl Scott		, care				Universit Maiden Sumame)	¥					
Mar	2 shouth and the and the and the traum		19a. Informant's Name/Relationship (7 Vernell J. Cla						r, City or Town, State, Zi						
	f Heal f Heal item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		ield Av Date T	e Baltimo 20c. Location - City or						
imo	Page ment o ant: if ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State (y)	cemetery, cren Oaklawn	natory or other pla Cemete		1		,Maryland					
Baltimore,	permit. Depart Import any Inj		21. Signal de o Editeral Service Licens	Mus	42	Name and Addr 210 Bel	ess of FacilityCha air Road	atman-H d-Balti	arris Fun more,MD 2	eral Home 1206					
~	Medical Examiner purial-transit	cal Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	5 CELL	1440	A W	with mots	Approximate Interval Between Onset and Death					
	te be ex nysician he burla		resoluting in Security East	d											
P.O. Box 68760	Aftending Physician: The law fequires that the death cfirtificate brideath. sctor. After this certificate has been signed by the attending physi y the funeral director, page 2 should be detached for use as the t	ıysician/Me	ıysician/Me	Physician/Med	ıysician/Me	hysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live Birth 2 E 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnan	су		23d. Date of de Month	livery Day Year
35, P.O	To the Hospital or Attending Physician: The law fequires that the dewinth 24 hours after death within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause g	iven in Part I.	1	b co use contribute to	the cause of death?					
Division of Vital Records,	The law fec the has bee bage 2 sho	Completed by		7				24a. Was a autop perfor	sy prior to death?	topsy findings available completion of cause of					
<u></u>	cian: T	Be	25. Was case referred to medical examiner?			26. F	lace of Death (Chec		TO NO TO TE	Daughtoria					
Ę	Physic this co	၉	1 ☐ Yes 2 12 No 27. — er of Death		2 ER/Dutpatien		4 U Nursing H	ome 5 1 Hesid	ence 6 XXOther (Spec	Residence					
o uoi	tending leath. or: After the funer	Certificate:	1		28b. Time of injury	28c. Inju wor M 1	ryat k?]Yes 2 □ No	28d. Describe h	ow injury occurred						
.≥	pital or Atten burs after deal eral Director: filled in by the		4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town		ŕ					
	thin 24 hours of the Funeral I	Medical	only one) 3 Certifying Nurs	sician: To the best of my ner: Dn the basis of exam the Practitioner: To the be	ination and/or investi	gation, in my onini	on death occurred :	at the time date ar	nd place and due to the	raucale) and manner stated					
	or with		29b. Signature and title of certifier	Payne	MI	29c. Licens	# 130 / a	2	29d. Date signed (Month	Day, Year					
			30. Name and address of person who o	ompleted cause of death	(Item 23a)/(Type-P	INAS	5t, (Billo	1/1/2	1118					
	Stat Registra	e ir	11. Date filed (40nts, 157, 2013	32. Registran	Signatura		· · · · · · · ·		1 111	-					

11-07423 Jared West

red West		Amend State of Maryland Department 1- For State Certificate			2011	110151
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	Reg. No. 2011 - 4365 (2. Date of Death 3. Time of Death		
edical Exami				Month October 3,		2014 hrs
A		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of De	eath
/		Peninsula Regional Medical Center	Salisbury	In Date of Dist	Wicomico	Distribution (Otata as
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		/lin.		reign
		221-88-1801 1 M 2 F 15	rs.	4-23-1	996	Country) MD
any		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
and show	5	DE Sussex Delmar				1 Yes 2 X No
Baltimore, MD 21215-0036 permit rages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene Planger and Plangertatt. If them 27 is marked other than "matural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 38324 Providence Church Road	10f. Zip Code 19940		og. Citizen of What C USA	Country?
ith the 23a or notifi			Non December of Missesia Osiain?	Cassif. Van as Na	I 14 Page Ar	moriage Indian Plack
eath w	Funeral	1 X Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue		White, etc	merican Indian, Black, c.
fter de I", or		1 Yes 2 No 3 Widowed 4 Divorced ITYes, Give Year or Detes: 1	Yes 2 No specify:		Specify: Wh	ite/Black
nours s natura	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedenting	ent's Usual Occupation (Give kind most of working life. DO NOT use		16b. Kind of Busine	ess/Industry
36 in 72 l	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	•	,		
d with	Completed	9 Stude		me (First, Middle, N	Education Maiden Surname)	n
215 be file rited o	Be	Jerry West	Rehecc	A Turk	ington	
221 hould lid Men is man	2		Rebecca ing Address (Street and Number			
MC and 2 si alth ar			4 Providence Chuosition (Name of cemetery,	urch Rd.	Delmar, D	
Baltimore, MD 21215-0036 eremit. Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If tiem 27 is marked other than nijury or other traumatic event, the <u>Medica</u>		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)		Salisbur	•
Itim it. Pag rrment ortant		4 Donation 5 Other Specify:				
Depa Depa Impo		David H. Thompson, CFSP	. Name and Address of Facility $_{ m H}$ sociation $501~{ m Si}$	olloway F now Hill	uneral Ho Rd. Salis	me Prof. bury,MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease a Multiple Blunt Force Injunes				Death
~·		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			=	_
cuted nd transit	Ä	d.				
tO, e be executed ysician and burial - transit	dical Examine	UNPENDED Z8b, 28e, per ME	g946 12/5/13 TR	T		ľ
760 ficate I g phys	/Me	23h Was decedent pregnant in the			23d. Date of deliv	very Day Year
Box 6876(e death certificate the attending physe ed for use as the b	iciar	past 12 months?	Fetal death 3Ectopic pree Other (Specify)	griancy	MOUTH	Day Teal
BO:	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown				
of Vital Records, P.O. Eng Physician: The law requires that the defends the certificate has been signed by the meral director, page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tol		to the cause of death?
ords, I w requires s been sig should be						autopsy findings available
COL	Completed			autops perfori	med? death	to completion of cause of
ital Recions: The secrificate		25. Was case referred to medical	26.Place of Death (Che	1 Yes 2	2 No 1 🗸	Yes 2 No
Vita hyrician this cer	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	- Iothan -		Residence 6 Of	ther:
1 of ling Ph After t funeral	n: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of			ow injury occurred	hen struck by motor
ttendi death. ctor:	atio	1 Natural 5 Pending Oct 3, 2017 1918 hrs 2 ✓ Accident Investigation 7:14	P.M. 1 Yes 2 ✓ No	vehicle		
Division bepital or Attendin hours after death. neral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) History and Park Stree	EE		street and Number or tate) ence Church Road	Rural Route Number, City
- 15 S 15 I		29a. Certifier				
ple the	Medical	(Check only one) 2 Wedical Examiner: On the bast of my knowledge, death occurrence one)				
To with To con	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		R	O.C.M.E.		October 4, 201	11
		30. Name and address of person who completed cause of death (Item 23a)	1 M. Palimara Street Dell	imore MD 240	222	
	ate	31. Date filed (Month. Day Year) 32. Registrar's Signature	0 W. Baltimore Street, Balt			
Regist		NOV 1 9 2013 Burne S. A.	alle			

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

ORIGINAL

J. Laron Locke, M.D.

31 Date filed (Month, Day

DHMH 17 Rev 1/2001

ORIGINAL